

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04263 / 04261					04263				
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> <u>21-1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Martin Manor Nursing Home</u>					d. STREET ADDRESS <u>Canal Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		Month	Day	Year
<u>Annie</u>			<u>Elizabeth</u>	<u>Ardinger</u>	<u>March</u>		<u>24</u>	<u>19</u>	<u>67</u>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<u>Jan. 29 1889</u>		<u>78</u> yrs.	Months <u>1</u>	Days <u>22</u>	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>Charles Ardinger</u>				14. MOTHER'S MAIDEN NAME <u>Lula Woltz</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Ida Ardinger</u> <u>Canal Rd.</u> <u>Williamsport Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral broncho pneumonia</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Advanced arteriosclerosis, generalized, 5-10 yrs</u> DUE TO (c) <u>Cerebral thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 1 - 1967</u> to <u>Mar 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar 11 1967</u> , and that death occurred at <u>21</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Edward W. Dill III</u>					22b. DATE SIGNED <u>3-24-67</u>		22c. PHYSICIAN'S NAME (Type) <u>217 W. Washington St Hagerstown, Md</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>March 27-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport Maryland</u>		
24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport Maryland</u>					25a. REC'D BY REGISTRAR <u>MAR 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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79

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04262

CERTIFICATE OF DEATH

04264

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro		75-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County		d. STREET ADDRESS 26 W. 3rd St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ethel May Balsiger		4. DATE OF DEATH Month 3- Day 10- Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-17-02
9. AGE (In years lost birthday) 64 yrs.		IF UNDER 1 YEAR Months 64 Days 64 Hours 64 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - -	
11. BIRTHPLACE (Country & State, or foreign country) Franklin Co. Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard King		14. MOTHER'S MAIDEN NAME Minnie Schrader	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. - -	
17. INFORMANT Mr. H. E. Balsiger		Address Waynesboro, Penna.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 296X IMMEDIATE CAUSE (a) Gastrointestinal and intracranial hemorrhage. DUE TO (b) Acute thrombocytopenic purpura. DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-5-67 , 19__, to 3-10-67 , 19__, that (I) (we) last saw the deceased alive on 3-9-67 , 19__, and that death occurred at 3:45 a.m. , from causes and on the date stated above.			
22a. SIGNATURE A. F. Abdullah		22b. DATE SIGNED 3-13-67	
22c. PHYSICIAN'S NAME (Type) A. F. Abdullah, M. D.		22d. ADDRESS 132 N. Potomac St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/12/1967	
23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION (City or Town) (County) (State) Waynesboro, Franklin, Pa.	
24. FUNERAL DIRECTOR Walter G. Shaw		25a. REC'D BY REGISTRAR MAR 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

02554

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

4
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04263 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04265

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY in 1b <u>4 hrs.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport RFD #2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>			d. STREET ADDRESS <u>Pinesburg</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ezra</u> <u>Keller</u> <u>Banzhoff</u>			4. DATE OF DEATH Month Day Year <u>March</u> <u>26</u> <u>1967</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14 1874</u>	9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months Days <u>1</u> <u>11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fishing Guide</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Banzhoff</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>216 03 1226A</u>		
17. INFORMANT <u>Mr. Amos Banzhoff</u>			Address <u>Williamsport Md RFD #2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Brain Hemorrhage and contusion</u> 9000 } DUE TO <u>accidental fall down basement steps</u> Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. } DUE TO (c) }					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>2</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Accidental fall down basement steps</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>2:00</u> <u>3/26/67</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Wmspt.</u>	(County) <u>Wash.</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Howard N. Weeks</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3/27/67</u>	
EXAMINER'S NAME (Type) <u>Howard N. Weeks, M. D.</u>		DEPUTY MEDICAL EXAMINER <u>580 Northern Ave., Hagerstown, Maryland</u>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 29-67</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport, Md.</u>	
23. FUNERAL DIRECTOR <u>Albert L.. Leaf Williamsport Md..</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>MAR 28 1967</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04264

04266

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leitersburg		c. LENGTH OF STAY IN lb 17 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leitersburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rd # 5				d. STREET ADDRESS Rd # 5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elmer Middle William Last Bingaman				4. DATE OF DEATH Month March Day 11 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-25-06		9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Steel mfg.		11. BIRTHPLACE (State or foreign country) Welsh Run, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John E. Bingaman				14. MOTHER'S MAIDEN NAME Martha Mummert			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 174-01-3577		17. INFORMANT Address Ella Bingaman Leitersburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to 9731 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Carbon Monoxide DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 15-30 Year	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Edward W. Ditto III		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Edward W. Ditto III, M.D.				22. DATE SIGNED 3-13-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3-14-67		23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Waynesboro, Pa.	
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home Hagerstown, Md.				25a. REC'D BY REGISTRAR MAR 15 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

23540

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MD
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04265

CERTIFICATE OF DEATH

04267

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cascade	
3. NAME OF DECEASED (Type or print) First Middle Last Edith Blanche Boppe		d. STREET ADDRESS Rd 1	
4. DATE OF DEATH Month Day Year March 15 19 67		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-6-1892
9. AGE (In years last birthday) yrs. 74		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (County & State, or foreign country) Indian Springs, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Grove		14. MOTHER'S MAIDEN NAME Anna Penner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Wm. A. Boppe		Address Cascade, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive repeated hemorrhage into gastro-intestinal tract. DUE TO (b) Unknown DUE TO (c) intermittently Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atherosclerotic heart disease			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 14 , 19 67 , to March 15 , 19 67 , that (I) (we) last saw the deceased alive on March 15 , 19 67 , and that death occurred at 2:05 M, from causes and on the date stated above.			
22a. SIGNATURE William T. Layman, M.D.		22b. DATE SIGNED March 17, 1967	
22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.		22d. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-18-67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home		25a. RECEIVED BY REGISTRAR DATE MAR 20 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

04307

04307

WASHINGTON
OFFICE
JANUARY 1941
MEMORANDUM
TO: THE SECRETARY OF THE ARMY
FROM: THE CHIEF OF THE BUREAU OF MILITARY PERSONNEL
SUBJECT: [Illegible]

[Illegible text block containing several paragraphs of a memorandum]

[Handwritten signature]

1-1-41
[Illegible text at the bottom of the page]

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/66

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Cascade		c. LENGTH OF STAY IN 1b 1 Week	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Shirley Viola Bowman		4. DATE OF DEATH Month March Day 6 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/25/35
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 32 yrs.
11. BIRTHPLACE (State or foreign country) Smithsburg Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marshall Bowman		14. MOTHER'S MAIDEN NAME Mary F. Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ((If yes give war or dates of service)) No.		16. SOCIAL SECURITY NO. Box 5	
17. INFORMANT Mrs. Marshall Bowman, Route #1, Cascade Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure 932.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia / Hypoxia / Asphyxia (c) Interval between onset and death Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) wandered away from home into Mountain area - apparently succumbed to elements	
20c. TIME OF INJURY Month, Day, Year Hour a.m. Unknown, p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.) Mountain Area nr. Ft. Ritchie Wash. Md.	20f. (City or town) (County) (State) Ft. Ritchie Wash. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE Edward W. Ditto III EXAMINER'S NAME (Type) Edward W. Ditto III MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, P.O. Box or County) Frederick Co., Md.	
22. DATE SIGNED 3-11-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/13/67	23c. NAME OF CEMETERY OR CREMATORY Bethel	23d. LOCATION (City or Town) (County) (State) Lantz #1, Frederick Co., Md.
24. FUNERAL DIRECTOR Walter V. Grove		ADDRESS Waynesboro Pa.	
25a. REC'D BY REGISTRAR DATE MAR 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04267

CERTIFICATE OF DEATH

04269

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Martin Manor Rest Home</u>		d. STREET ADDRESS <u>16 Avalon Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Jessa</u> Middle <u>Pearl</u> Last <u>Brill</u>		4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 21, 1887</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Lincoln, Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alexander P. Fletcher</u>		14. MOTHER'S MAIDEN NAME <u>Jessa Grady</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-30-9432A</u>	
17. INFORMANT <u>J. Brill</u>		Address <u>29 Redwood Dr. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno carcinoma colon & sigmoid.</u> <u>1538</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>igial Metastasis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-21-</u> , 19 <u>66</u> , to <u>3-4-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb 25</u> , 19 <u>67</u> , and that death occurred at <u>3:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward W. Dittus III</u>		22b. DATE SIGNED <u>3-4-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Dittus III, MD</u>		22d. ADDRESS <u>217 W. Washington St. Hagerstown Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Washington, Md.</u>
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u> <u>Rest Haven Funeral Chapel</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAR 7 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04268

CERTIFICATE OF DEATH

04270

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>6 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Smithburg</u> <u>21-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Avalon Manor, Inc.</u>			d. STREET ADDRESS <u>Holiday Acres, Box 262</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Catherine</u> Last <u>Brown</u>			4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>19 67</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 16, 1893</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>1</u> Hours <u>Min.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lansing, Michigan</u>	
13. FATHER'S NAME <u>Charles Foerster</u>			14. MOTHER'S MAIDEN NAME <u>Mary Sandowsky</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. James M. Archer</u> <u>2131 Fairfax Rd.</u> Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Cerebral Vasc. Disease</u> DUE TO (c) <u>2 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>66</u> , to <u>March 17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Mar 17</u> , 19 <u>67</u> , and that death occurred at <u>4:45 A.M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>Lloyd A. Hoffman</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>		22d. ADDRESS <u>214 N. Pot. St. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>2-19-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Lansing Michigan</u>	
24. FUNERAL DIRECTOR <u>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</u>			25a. REC'D BY REGISTRAR DATE <u>MAR 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04269

CERTIFICATE OF DEATH

04271

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY FRANKLIN ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN			c. LENGTH OF STAY IN TB 5 YRS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL FAYETTEVILLE 75-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) AVALON MANOR NURSING HOME				d. STREET ADDRESS R.D.# 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SUELLA Middle RINEHART Last CASPER				4. DATE OF DEATH Month MARCH Day 12 Year 1967			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 14, 1895	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PARTNER		10b. KIND OF BUSINESS OR INDUSTRY ORCHARD		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO., MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDMUND P. COHILL				14. MOTHER'S MAIDEN NAME MARY RINEHART			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-38-9683A		17. INFORMANT MR. JOHN P. CASPER Address FAYETTEVILLE R.D.#.3 PENNSYLVANIA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myeloid metaplasia of spleen DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____						INTERVAL BETWEEN ONSET AND DEATH 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-9, 1962 , to 3-12, 1967 , that (I) (we) last saw the deceased alive on 31-11-1967 , and that death occurred at 3:30 A.M. , from causes and on the date stated above.							
22a. SIGNATURE John H. Hornbaker M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-13-67	
22c. PHYSICIAN'S NAME (Type) JOHN H. HORNBAKER M.D.				22d. ADDRESS 154 W. WASH. ST. HAGERSTOWN, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MARCH 15, 1967	23c. NAME OF CEMETERY OR CREMATORY HOMEWOOD CEMETERY		23d. LOCATION (City or Town) (County) (State) PIITTSBURGH, PENNSYLVANIA			
24. FUNERAL DIRECTOR CHARLES M. ROUZER ADDRESS HAGERSTOWN, MARYLAND				25a. REC'D BY REGISTRAR MAR 17 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04270

CERTIFICATE OF DEATH

04272

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Knoxville		c. LENGTH OF STAY IN 1b 3 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Knoxville Rfd. 1 21-1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS Weaverton			
3. NAME OF DECEASED (Type or print) First Elsie Middle O. Last Castle				4. DATE OF DEATH Month March Day 31 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1906	9. AGE (In years last birthday) yrs. 60	IF UNDER 1 YEAR Months 9 Days 26 Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Middletown, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ira O. Moss				14. MOTHER'S MAIDEN NAME Hattie Mae Cochran			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 215-26-8159		17. INFORMANT Mr. Cornelius W. Castle, Jr. Rfd. 1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 10 months Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-7- , 19 63 , to 1-9- , 19 67 , that (I) (we) last saw the deceased alive on 1-9- , 19 67 , and that death occurred at 4P M, from causes and on the date stated above.							
22a. SIGNATURE Joseph Secondari				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-1-67	
22c. PHYSICIAN'S NAME (Type) JOSEPH SECONDARI				22d. ADDRESS Boonsboro Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-3-67		23c. NAME OF CEMETERY OR CREMATORY Brownsville Cemetery		23d. LOCATION (City or Town) (County) (State) Brownsville, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25. REC'D BY REGISTRAR APR 4 1967		25b. REGISTRAR'S SIGNATURE James Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04271

04273

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAHERSTOWN			c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN MARYLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle CHANEY Last CHANEY			4. DATE OF DEATH Month 3 Day 25 Year 19 67				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10.30.1904		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) CLEARSPRING MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM CHANEY				14. MOTHER'S MAIDEN NAME SUSAN M POWELL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 213.24.9699		17. INFORMANT MARTIN VB. BOSTER 34 W. FRANKLIN ST.		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>23 March 1967</u> , to <u>death</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>25 March 19 67</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>John C. Stauff</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>27 March 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John C. Stauff</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3.29.67		23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEMORIAL		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASHINGTON MD.	
24. FUNERAL DIRECTOR <u>Howard J. Stone</u>				ADDRESS <u>Hagerstown Md</u>		25a. REC'D BY REGISTRAR DATE MAR 31 1967	
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04333

04333

HABERSTOWN MARYLAND

4 DAYS

HABERSTOWN

WASHINGTON COUNTY MARYLAND

CHANEY

WILLIAM

10.30.1000

WASHINGTON MARYLAND

WAGON

ROBERT M. POWELL

WILLIAM CHANEY

01.04.0000 MARTIN 18.0.0000 31.0.0000

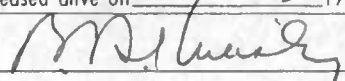
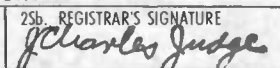
Handwritten signature and date: 10/11/1987

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04272

04274

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN TB 70 YEARS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 733 MARYLAND AVENUE				d. STREET ADDRESS 733 MARYLAND AVENUE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last HARRY THOMAS CLARK				4. DATE OF DEATH Month Day Year MARCH 24 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 12 1874		9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MERCHANT			10b. KIND OF BUSINESS OR INDUSTRY LIQUOR STORE		11. BIRTHPLACE (County & State, or foreign country) PHILADELPHIA PENNSYLVANIA		
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME THOMAS CLARK				14. MOTHER'S MAIDEN NAME CECILIA STOLER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-09-9106A		17. INFORMANT MRS MYRA L MARTIN 7957 VIEW STREET HAGERSTOWN MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden Indefinite							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from Dec. 13 , 19 63 , to March 24 , 19 67 , that (I) (we) last saw the deceased alive on March 23 , 19 67 , and that death occurred at 12:15A. M, from causes and on the date stated above.							
22a. SIGNATURE 			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/25/67		
22c. PHYSICIAN'S NAME (Type) B.B. KNEISLEY M.D.			22d. ADDRESS 148 W WASHINGTON ST. HAGERSTOWN MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/27/67		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASHINGTON MD	
24. FUNERAL DIRECTOR CHARLES M ROUZER HAGERSTOWN MARYLAND				25a. REC'D BY REGISTRAR MAR 28 1967		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03554

03554

MAR 28 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **04275****04273**

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Athalinda Middle Creager Last Creager		4. DATE OF DEATH Month March Day 10 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1879
9. AGE (In years last birthday) 87		10. IF UNDER 1 YEAR Months 87 Days 87 Hours 87 Min. 87	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Creager		14. MOTHER'S MAIDEN NAME Bettie Kitzmiller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT A. Pauline Stoner, 304 S. Church St., Waynesboro		Address Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive failure and pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH Sev. days years	
21. I certify that I attended the deceased from July , 1964, to March , 1967, that I last saw the deceased alive on 3/8/67 , 19, and that death occurred at 8:25 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 580 Northern Avenue DATE SIGNED	
ACTUAL SIGNATURE Howard N. Weeks		M.D. 580 Northern Avenue	
PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/13/1967	22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery	22d. LOCATION (City, town, or county) (State) Waynesboro Penna.
23. FUNERAL DIRECTOR'S SIGNATURE H. Martin Roe		ADDRESS Waynesboro, Penna.	
24a. REC'D BY REGISTRAR MAR 14 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1933

Registration No. 123456789

Decedent's Name: John Doe

Age: 45 Years

Sex: Male

Date of Death: Jan 15, 1933

Place of Death: Baltimore, Md.

Cause of Death: Heart Disease

Signature of Physician: J. Smith

Signature of Physician		Signature of Registrar	
Name of Physician		Name of Registrar	
Address of Physician		Address of Registrar	
Signature of Coroner		Signature of Undertaker	
Name of Coroner		Name of Undertaker	
Address of Coroner		Address of Undertaker	
Signature of Burial Place		Signature of Burial Place	
Name of Burial Place		Name of Burial Place	
Address of Burial Place		Address of Burial Place	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04274

CERTIFICATE OF DEATH

04276

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>2 Weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Boonsboro</u> 21-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>Rfd. 1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Iona Katherine Greager</u>				4. DATE OF DEATH Month Day Year <u>March 23, 19 67</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 9, 1922</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>5 14</u>		11. BIRTHPLACE (County & State, or foreign country) <u>San Mar, Wash. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>San Mar, Wash. Co., Md.</u>	
13. FATHER'S NAME <u>Perry O. Green</u>				14. MOTHER'S MAIDEN NAME <u>Cora M. Harrison</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>219-12-1127</u>		17. INFORMANT Address <u>Mr. Charles W. Greager, Boonsboro Rfd.1, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of cervix & metastases</u> DUE TO (b) <u>Uremia due to obstructive jaundice</u> DUE TO (c) <u>Hypertensive C. V. Disease</u> 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>see 1965</u> <u>march 9-67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 11 - 1967</u> , to <u>march 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>3-22 19 67</u> and that death occurred at <u>4:55 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Sidney Kovenstein</u>				22b. DATE SIGNED <u>3-23-67</u>		22c. PHYSICIAN'S NAME (Type) <u>SIDNEY KOVENSTEIN</u>	
22d. ADDRESS <u>FUNKSTOWN MD</u>				22e. ADDRESS <u>FUNKSTOWN MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-25-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Myersville EUB. Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Myersville, Md.</u>	
24. FUNERAL DIRECTOR <u>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00330

1941

1941

Case of James E. McLaughlin
born 1901, died 1941, was
found in the McLaughlin
house at 1000
on 10-10-41.

James

Arthur J. McLaughlin
3-1-41
10-10-41
10-10-41
10-10-41

1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 04275 04277 CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY WASHINGTON b. STATE MARYLAND c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HANCOCK d. LENGTH OF STAY IN 1b 38 YEARS					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HANCOCK d. STREET ADDRESS 136 WEST HIGH STREET				
3. NAME OF DECEASED (Type or print) PRESTON ELWOOD CROUSE					4. DATE OF DEATH Month MARCH Day 7 Year 1967				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/17/1899		9. AGE (In years last birthday) 67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PETROLEUM SALES		10b. KIND OF BUSINESS OR INDUSTRY MORGAN CO., W.VA.		11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ASBURY HOUSTON CROUSE	
14. MOTHER'S MAIDEN NAME CATHERINE VIRGINIA SOTTLE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. W.W. 1 212-03-8595		17. INFORMANT 136 W. HIGH STREET ETHEL O. CROUSE HANCOCK, MARYLAND		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Myocardial Infarct Pulmonary Edema	
19. INTERVAL BETWEEN ONSET AND DEATH ?		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 12/7 , 19 67 , to 12/7 , 19 67 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above.	
22a. SIGNATURE <i>L.M. Shaffer</i>		22b. DATE SIGNED 12/7/67		22c. PHYSICIAN'S NAME (Type) L.M. SHAFFER M.D.		22d. ADDRESS MAIN STREET, HANCOCK, MARYLAND		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE THEREOF 3/10/67		23c. NAME OF CEMETERY OR CREMATOR OAKLAND METHODIST		23d. LOCATION (City, town or county) (State) MORGAN CO., WEST VIRGINIA		24. FUNERAL DIRECTOR <i>Howard J. ...</i>		25a. REC'D BY REGISTRAR MAR 14 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. REGISTRAR'S NAME Charles Judge		25d. REGISTRAR'S ADDRESS ...		25e. REGISTRAR'S PHONE ...		25f. REGISTRAR'S FAX ...	

04377

04377

WASHINGTON

MARYLAND

WASHINGTON

HANDOOK

38 YEARS

HANDOOK

135 WEST HIGH STREET

135 WEST HIGH STREET

MARCH

RECORD GROUP

RECORD GROUP

67

02/12/1989

MALE WHITE

U.S.A.

PETROLEUM SALES MORGAN CO., W.VA.

CATHERINE VIRGINIA GOTTLE
135 W. HIGH STREET
HANDOOK, MARYLAND

ARMY HUNTER GROUP

U.S.A.

MAIN STREET, HANDOOK, MARYLAND

L.M. SHAFER M.D.

XXXXX

MORGAN CO., WEST VIRGINIA

OAKLAND METHODIST

02/12/1989

BUTAL

MAR 1 1987

1

3

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04276

CERTIFICATE OF DEATH

04278

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 45 YRS.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		d. STREET ADDRESS 200B HAYES AVE.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SARAH Middle ELIZABETH Last CUSTER		4. DATE OF DEATH Month MARCH Day 23 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/20/1894
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MORGAN PRICE		14. MOTHER'S MAIDEN NAME SUAN BREEDEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-09-1133	
17. INFORMANT MR. JOSEPH W. CUSTER		HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Indefinite		INTERVAL BETWEEN ONSET AND DEATH 331X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous it cerebral accident. Diabetes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-26 , 19 49 , to death , 19 67 , that (I) (we) last saw the deceased alive on 3-18 , 19 67 , and that death occurred at 1:20 PM from causes and on the date stated above.			
22a. SIGNATURE Robert F. Keadle M.D.		22b. DATE SIGNED 3-24-67	
22c. PHYSICIAN'S NAME (Type) Robert F. Keadle, M. D.		22d. ADDRESS Hagerstown, Md. 21740	
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE THEREOF 3/27/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.
24. FUNERAL DIRECTOR W. J. Normant, Hagerstown, Md.		25a. REC'D BY REGISTRAR MAR 29 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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REFERENCES

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04277

04279

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1719 Homewood Road</u>		d. STREET ADDRESS <u>1719 Homewood Road</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Francis</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>19 67</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 31, 1904</u>
9. AGE (In years lost birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dust Col. Mfg.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John R. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Huffer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-6138</u>	
17. INFORMANT <u>Mrs. Goldie Davis</u>		Address <u>1719 Homewood Rd. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>athrosclerotic coronary artery disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4201</u>			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u> </u> years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Howard N. Weeks</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		Address (Street, city, town, or county) <u>580 Northern Ave. Hagerstown, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/29/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Washington, Md.</u>
24. FUNERAL DIRECTOR <u>Wm. G. Harst</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
Address <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

DATE MAR 30 1967

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Robert L. Smith

W. C. Hunt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04278

CERTIFICATE OF DEATH

04280

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 45 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL			d. STREET ADDRESS 335 S. CANNON AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALFREDO Middle N.M.N. Last DeFELICE			4. DATE OF DEATH Month MARCH Day 9 Year 19 67		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 29, 1899	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TURBINE TENDER		10b. KIND OF BUSINESS OR INDUSTRY CEMENT PLANT		11. BIRTHPLACE (County & State, or foreign country) ITALY	
13. FATHER'S NAME JOSEPH DeFELICE			14. MOTHER'S MAIDEN NAME GIUANNA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-10-6785		17. INFORMANT HAGERSTOWN, MARYLAND MRS. EVA DeFELICE 335 S. CANNON AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Biliary Pancreatitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured gall Bladder DUE TO (c) 3 day					INTERVAL BETWEEN ONSET AND DEATH 3 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/12, 1962 to 3/9/67 , 19 67 , that (I) (we) last saw the deceased alive on 3/9/67 19 67 , and that death occurred at 7:50 PM , from causes and on the date stated above.					
22a. SIGNATURE Lawrence L. Packer, Jr. M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) LAWRENCE L. PACKER, JR. M.D.			22b. DATE SIGNED 3/10/67		
22d. ADDRESS 145 W. WASHINGTON ST. HAGERSTOWN, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MARCH 13, 1967	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, MARYLAND	
24. FUNERAL DIRECTOR CHARLES M. ROUZER HAGERSTOWN, MARYLAND			25a. REC'D BY REGISTRAR MAR 15 1967		25b. REGISTRAR'S SIGNATURE f Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and promptly event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04279

CERTIFICATE OF DEATH

04281

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Calvin Last Deibert		4. DATE OF DEATH Month March Day 18 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1901
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) fireman		11b. KIND OF BUSINESS OR INDUSTRY furniture Mfg.	
12. BIRTHPLACE (County & State, or foreign country) Cavetown, Md.		13. CITIZEN OF WHAT COUNTRY?	
14. FATHER'S NAME Hezekiah W. Deibert		15. MOTHER'S MAIDEN NAME Mary Ann Burger	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		17. SOCIAL SECURITY NO. 214-09-7287	
18. INFORMANT Hazel Ecton, Hagerstown, Md.		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerotic heart disease DUE TO (c) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
20. INTERVAL BETWEEN ONSET AND DEATH minutes			
21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension Essential			
22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
23a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
25. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 3-18		26. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		28. (City or town) (County) (State)	
29. I certify that (I) (this hospital) attended the deceased from October 11, 1959 , to death , that (I) (we) last saw the deceased alive on 3-18 1967, and that death occurred at 2:04 P.M. from causes and on the date stated above.			
30. SIGNATURE Robert F. Keadle M.D.		31. DATE SIGNED 3-20-67	
32. PHYSICIAN'S NAME (Type) Robert F. Keadle, M. D.		33. ADDRESS Hagerstown, Md. 21740	
34. BURIAL, CREMATION, REMOVAL (Specify) burial		35. DATE THEREOF 3-21-67	
36. NAME OF CEMETERY OR CREMATORY Cavetown Cemetery		37. LOCATION (City or Town) (County) (State) Cavetown, Md.	
38. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		39. REC'D BY REGISTRAR MAR 27 1967	
40. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04280

CERTIFICATE OF DEATH

04282

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle, Pa.</u> 75-3	
c. LENGTH OF STAY IN 1b <u>3 Days</u>		d. STREET ADDRESS <u>36 W. Balto. St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Larlock Mem. Conv. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARTHA F. DETRICH</u>		4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/5/1868</u>
9. AGE (In years lost birthday) <u>98</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel S. Hollinger</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Funk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mary E. Detrich</u>		Address <u>Greencastle, Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> DUE TO 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-17</u> , 19 <u>67</u> , to <u>3-19</u> , 1967, that (I) (we) last saw the deceased alive on <u>3-19</u> , 19 <u>67</u> , and that death occurred at <u>5:10 a.m.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>		22b. DATE SIGNED <u>3-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		22d. ADDRESS <u>215 W. Washington St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>	23b. DATE THEREOF <u>3/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Greencastle Pa.</u>
24. FUNERAL DIRECTOR <u>A. E. Minnich</u>		25a. REC'D BY REGISTRAR <u>MAR 22 1967</u>	
ADDRESS <u>Greencastle, Pa.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04281

04283

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 1212 W. WASHINGTON ST.	
3. NAME OF DECEASED (Type or print) First LILLIAN Middle M. Last DIETZ		4. DATE OF DEATH Month MARCH Day 10 Year 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/5/1880
9. AGE (In years lost day) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME CLAGGETT W. RANDALL		14. MOTHER'S MAIDEN NAME SARAH JOHNSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-09-9358A	
17. INFORMANT MR. HARRY C. RANDALL		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9020 IMMEDIATE CAUSE (a) Bronche pneumonia Secondary DUE TO (b) to Fracture of Femur Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell when getting into bed at Home.	
20c. TIME OF INJURY Month, Day, Year 10th am. 10-30 1966	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Hagerstown Wash Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Dittus III		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Dittus III		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/13/67	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.	
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.		DATE MAR 14 1967	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04282

CERTIFICATE OF DEATH

04284

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 65 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 1707 OAK HILL AVENUE	
3. NAME OF DECEASED (Type or print) First JOHN Middle CARL Last DITMER		4. DATE OF DEATH Month MARCH Day 10 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 13, 1891
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SHEET METAL WORKER	11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND CO., PENNA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EDWARD DITMER	
14. MOTHER'S MAIDEN NAME EMMA KUNKLE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 214-09-7381A		17. INFORMANT MRS. WILMER MOSS 1707 OAK HILL AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - Dx. frontal sinus DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 8 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. , 19 55 , to Mar 10 , 19 67 , that (I) (we) last saw the deceased alive on Mar 10 , 19 67 , and that death occurred at 6 P M, from causes and on the date stated above.			
22a. SIGNATURE Lloyd A. Hoffman		22b. DATE SIGNED 3/11/67	
22c. PHYSICIAN'S NAME (Type) LLOYD A. HOFFMAN M.D.		22d. ADDRESS 214 N. POTOMAC STREET HAG., MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MARCH 13, 1967	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN MARYLAND
24. FUNERAL DIRECTOR CHARLES M. ROUZER HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR MAR 15 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY		WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		MARYLAND		b. COUNTY		WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b LIFE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL						d. STREET ADDRESS 61 NORTH AVENUE						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day Year	
MARY		GRACE		DOWNIN		MARCH		20		19		67	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		SEPT. 9 1879		87 yrs.		Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TEACHER				10b. KIND OF BUSINESS OR INDUSTRY EDUCATION		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME C GEORGE BORYER						14. MOTHER'S MAIDEN NAME MARGARET GARMAN							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT MARGARET B GAINES LAGUNA HILLS CALIF.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) Arteriosclerosis - Gen. yrs.										INTERVAL BETWEEN ONSET AND DEATH 11 days 16 days yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from July, 1939, to Mar-20, 1967, that (I) (we) last saw the deceased alive on Mar-20 1967, and that death occurred at 11:45 A.M. from causes and on the date stated above.													
22a. SIGNATURE Lloyd A. Hoffman M.D.								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/21/67			
22c. PHYSICIAN'S NAME (Type) LLOYD A HOFFMAN M.D.								22d. ADDRESS 214 N. POTOMAC ST. HAGERSTOWN MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 3/23/67		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY				23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASHINGTON MD.			
24. FUNERAL DIRECTOR CHARLES M ROUZER HAGERSTOWN MARYLAND						25a. REC'D BY REGISTRAR MAR 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					

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THE OFFICE OF THE ATTORNEY GENERAL
STATE OF NEW YORK
ALBANY, N. Y.
JANUARY 1, 1907
TO THE HONORABLE THE COMMISSIONER OF THE LAND OFFICE
SIR:
I have the honor to acknowledge the receipt of your letter of the 29th inst. in relation to the above subject.
In reply to inform you that the same has been forwarded to the proper authorities for their consideration.
Very respectfully,
J. B. [Signature]
ATTORNEY GENERAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04284					04286				
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>5 Weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Co. Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RFD2, Smithburg Md.</u> d. STREET ADDRESS <u>21-1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>Virginia</u> Last <u>Draper</u>			4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>19 67</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 6, 1905</u>		9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months <u>62</u> Days <u>62</u> Hours <u>62</u> Min. <u>62</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		
13. FATHER'S NAME <u>John Ira Grove</u>					14. MOTHER'S MAIDEN NAME <u>Anna Barbara Renner</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>James T. Draper Sr.</u> Address <u>RFD2, Smithburg.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus, Massive</u> <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Thrombosis of Femoral and iliac veins</u> DUE TO (c) <u>Intracranial hemorrhage (intracerebral) with hemiplegia</u> <u>5 weeks</u>								INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>2 days ?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertension, Diabetes Mellitus</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>p.m.</u> <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 26</u> , 19 <u>67</u> , to <u>March 29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 29</u> , 19 <u>67</u> , and that death occurred at <u>10:05 AM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Archie Robert Cohen</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 30, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u>					22d. ADDRESS <u>Clear Spring, Maryland 21722</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>April 1, 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Clear Spring, Maryland</u>		
24. FUNERAL DIRECTOR <u>Donald E. Thompson</u>					ADDRESS <u>Clear Spring,</u>		25a. REC'D BY REGISTRAR <u>APR 5 1967</u>		
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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[Faint, mostly illegible text covering the main body of the page, possibly a form or report.]

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MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04285

04287

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clear Spring, Md.		c. LENGTH OF STAY IN 1b 8 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural Clear Spring, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ignatious Samuel Drury		4. DATE OF DEATH Month Mar. Day 5 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1891
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 5 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Franklin Co. Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Luther Drury		14. MOTHER'S MAIDEN NAME Ellen Britton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-01-8219	
17. INFORMANT Mrs Annie Drury		Address Clear Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 yrs (c)			
19. INTERVAL BETWEEN ONSET AND DEATH 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 11-2 , 19 64 , to 3-6 , 19 67 , that (1) (we) last saw the deceased alive on 2-20 , 19 67 , and that death occurred at 10:30 M, from causes and on the date stated above.			
22a. SIGNATURE Dr. M. E. Byrkit, M. D.		22b. DATE SIGNED March 6, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. M. E. Byrkit, M. D.		22d. ADDRESS 28 W Potomac St. Williamsport, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/8/67	23c. NAME OF CEMETERY OR CREMATORY Pinesburg Mennonite	23d. LOCATION (City or Town) (County) (State) Clear Spring, Md.
24. FUNERAL DIRECTOR Margaret Rowland		25a. REC'D BY REGISTRAR 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL 24 HOURS AFTER DEATH. The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been retained by the attending physician and completely in by the funeral director. After this certificate has been signed by the attending physician and completely in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04286 CERTIFICATE OF DEATH 04288

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>18 Days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Avalon Manor</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Chambersburg</u> <u>75-3</u>			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Eshel</u> <u>Newton</u> <u>I</u> <u>Eshelman</u>			4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1967</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1901</u> <u>65</u> yrs.	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>3</u> Days <u>8</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refuse collector</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co. Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>16000 G. Eshelman</u>			14. MOTHER'S MAIDEN NAME <u>Mary Wolford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>195-28-0445</u>			17. INFORMANT <u>Mrs Della R Eshelman</u> Address <u>41 Chambersburg, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis - Generalized</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (the hospital) attended the deceased from <u>Feb. 19</u> , 19 <u>67</u> to <u>3-8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/8</u> , 19 <u>67</u> , and that death occurred at <u>12 M</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Carol A. Hoffman</u> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>3/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>			22d. ADDRESS <u>214 N. Potomac St. Hagerstown, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fetterhott Chapel Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Franklin Penna</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert R. Bachman</u>			ADDRESS <u>Chambersburg, Pa.</u>			RECORDED BY REGISTRAR <u>Charles Judge</u> DATE <u>MAR 14 1967</u>	

04388

04388

MAR 14 1961

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04287

04289

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN MD.			c. LENGTH OF STAY IN 1b 2 WKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HANCOCK 21-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 217 DALE ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELMER Middle WILLIAM Last FLOWERS				4. DATE OF DEATH Month 3 Day 10 Year 19 67			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6.1.1900		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FORMAN, SOUTHERN PIPE LINE CO.			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON COUNTY MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ALBERT FLOWERS				14. MOTHER'S MAIDEN NAME ANNIE FISHER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 203.07.6454		17. INFORMANT MARY M FLOWERS Address 217 DALE ST. HANCOCK MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X <i>Arteriosclerosis</i> DUE TO (b) <i>Nephrosclerosis</i> DUE TO (c) <i>Arterio-sclerotic Cardio. Dis.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <i>2 wks.</i> <i>grs.</i> <i>grs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hepatitis magn.</i> <i>Brachitis</i> <i>emphysema. ? Nephros.</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 27 Feb , 19 67 , to 10 Mar , 19 67 , that (I) (we) last saw the deceased alive on 10 Mar , 19 67 , and that death occurred at 8 P M, from causes and on the date stated above.							
22a. SIGNATURE <i>Richard T. Binford</i> 22c. PHYSICIAN'S NAME (Type) Richard T. Binford, M. D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 13 Mar 67	
22d. ADDRESS 1135 Potomac Avenue Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3.13.67		23c. NAME OF CEMETERY OR CREMATORY ROGHER HEIGHTS		23d. LOCATION (City or Town) (County) (State) RURAL HANCOCK WASHINGTON MD.	
24. FUNERAL DIRECTOR <i>Howard J. Stone</i> HANCOCK MD				25a. REC'D BY REGISTRAR MAR 15 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

UNITED STATES DEPARTMENT OF JUSTICE
DIVISION OF INVESTIGATION
WASHINGTON, D. C. 20535

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HANCOCK COUNTY HOSPITAL

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WASHINGTON COUNTY MD. U.S.A.

WASHINGTON COUNTY MD. U.S.A.

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HANCOCK COUNTY MD. U.S.A.

HANCOCK COUNTY MD. U.S.A.

[Faint, mostly illegible handwritten notes and signatures covering the lower half of the page.]

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04288

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04290

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN b 1 DAY		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL			d. STREET ADDRESS 31 E. CHURCH ST.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last EUGENIA MARIE GLADHILL			4. DATE OF DEATH Month Day Year MARCH 16 19 67		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/3/1963		9. AGE (In years last birthday) 3 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ROLLAND E. GLADHILL			14. MOTHER'S MAIDEN NAME PATRICIA MEADE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address WILLIAMSPORT MD. MRS. PATRICIA M. GLADHILL		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Communicated Exposed Fracture Skull Left DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Parietal With Brain Laceration & Intra- DUE TO (c) cranial Hemorrhage.					INTERVAL BETWEEN ONSET AND DEATH 8 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in car which was in head on collision.			
20c. TIME OF INJURY Month, Day, Year Hour 3:05 p.m. 3-16-19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State R# 68 Williamsport, Washington, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		M.D.		22. DATE SIGNED 3-17-67	
23a. BURIAL, CREMATION, OR OTHER DISPOSITION BURIAL		23b. DATE THEREOF 3/18/67		23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEM. GARDENS HAGERSTOWN MD.	
23d. LOCATION (City or Town) (County) (State) HAGERSTOWN MD.		23e. REC'D BY REGISTRAR 21 1967		23f. REGISTRAR'S SIGNATURE Charles Judge	

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Figure 1 illustrates the experimental setup. A participant is seated at a table, viewing a screen. The screen displays a 'Stimulus' area containing a 'Target' and a 'Response' area. The participant's hand is positioned over the 'Response' area, ready to interact with the stimulus.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
04289					04291					
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Franklin					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro 15-3					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garlock Nursing Home					d. STREET ADDRESS 30 Cottage Street,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MIDDLE Last WILLIAM EDWARD GROSSNICKLE					4. DATE OF DEATH Month Day Year March 10, 1967					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1, 1877		9. AGE (In years last birthday) 90		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist			10b. KIND OF BUSINESS OR INDUSTRY Landis Tool Co.		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Leonard Grossnickle					14. MOTHER'S MAIDEN NAME Mary Renner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. *****		17. INFORMANT Address Kenneth Grossnickle, Pennsylvannia.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Arteriosclerosis, generalized 25 yrs DUE TO (c) + Arteriosclerotic heart disease								INTERVAL BETWEEN ONSET AND DEATH 5 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prostate hypertrophy, Benign. Hypochromic Anemia								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			20g. (City or town) (County) (State)			20h. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-4 - 1967, to 3-10 - 1967, that (I) (we) last saw the deceased alive on 3-4 - 1967, and that death occurred at 12:30 PM, from the causes and on the date stated above.										
22a. SIGNATURE Edward W. D. Holt, M.D.					22b. DATE SIGNED 3-10-67			22c. PHYSICIAN'S NAME (Type) Edward W. D. Holt, M.D.		
22d. ADDRESS 217 W. Washington St Hagerstown, Md										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3/12/67		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery			23d. LOCATION (City, town or county) (State) Middletown, Fred. Co. Md.		
24. FUNERAL DIRECTOR Gladhill Company, Middletown, Maryland					25a. REC'D BY REGISTRAR MAR 13 1967			25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04290

CERTIFICATE OF DEATH

04292

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>5 /Weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>21.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>			d. STREET ADDRESS <u>17 Public Square</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>BERTHA LORRAINE GUESSFORD</u>			4. DATE OF DEATH <u>March 26 1967</u> 19 <u>19</u> Month Day Year		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan'y 10 1902</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stitcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Co</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Parkersburg W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Leonidas Roane</u>		
14. MOTHER'S MAIDEN NAME <u>Bessie (No Record)</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>214-09-9180</u> <u>214-09-7230D</u>		
16. INFORMANT <u>James R. Middlekauff</u>			Address <u>210 Hagesr St</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolus</u> DUE TO <u>Posterior coronary ischemia</u> (b) <u>Arterio sclerosis, generalized</u> DUE TO <u>3 weeks</u> (c) <u>years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia. Hepatic cirrhosis</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from <u>2/21</u> , 19 <u>67</u> , to <u>3/26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/25</u> , 19 <u>67</u> , and that death occurred at <u>6:45 AM</u> , from causes and on the date stated above.		
22a. SIGNATURE <u>George Hennings</u>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>George Hennings</u>			22d. ADDRESS <u>318 N. Potomac St. Hagerstown, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>3/28/67</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Maryland</u>		
24. FUNERAL DIRECTOR <u>Andrew K. Coffman Funeral Home Inc.</u> <u>Hagerstown, Maryland</u>			25a. REC'D BY REGISTRAR <u>MAR 30 1967</u>		
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04291 CERTIFICATE OF DEATH 04293

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsport c. LENGTH OF STAY IN Ib Lifetime d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 22 W. Potomac Street		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsport 21-1 d. STREET ADDRESS 22 W. Potomac Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last David Mc Kendree Harsh		4. DATE OF DEATH Month Day Year March 23 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb.. 24 1883
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 0 Days 27	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Tender		10b. KIND OF BUSINESS OR INDUSTRY Tavern	11. BIRTHPLACE (County & State, or foreign country) Williamsport Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME David H. Harsh	
14. MOTHER'S MAIEN NAME Malinda Wilson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 219-12-0501		17. INFORMANT Miss. Louise Harsh Williamsport Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Atherosclerosis (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 10 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Jan 1965, to 3-23 1967, that (I) (we) last saw the deceased alive on 3-23 1967, and that death occurred at 3:38 A.M. from the causes and on the date stated above.	
22a. SIGNATURE M.E. Byrkit		22b. DATE SIGNED 3-23-67	
22c. PHYSICIAN'S NAME (Type) M.E. Byrkit		22d. ADDRESS Williamsport Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 25-67	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR ADDRESS Albert L. Leaf Williamsport Md.		25a. REC'D BY REGISTRAR DATE MAR 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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3

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04292

04294

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN TB 10 YRS.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 1016 POTOMAC AVENUE			
3. NAME OF DECEASED (Type or print) First MARY Middle LEDBETTER Last HEGELER				4. DATE OF DEATH Month MARCH Day 15 Year 19 67			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 22, 1913		9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 Year Months Days Hours Min.	IF UNDER 24 Hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY MINING CORP.		11. BIRTHPLACE (County & State, or foreign country) CALHOUN CO., ALABAMA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EMMETT W. LEDBETTER				14. MOTHER'S MAIDEN NAME JESSIE JONES			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 111-22-7311		17. INFORMANT HAGERSTOWN, MARYLAND MR. H. HARTLEY HEGELER 1016 POTOMAC AVE.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Thrombosis DUE TO (c) Arterio sclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 18 hrs. 18 hrs. 5 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1942 , 1957, to 1967 that (I) (we) last saw the deceased alive on March 15 1967, and that death occurred at 4:15 AM , from causes and on the date stated above.							
22a. SIGNATURE Lloyd A. Hoffman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/17/67	
22c. PHYSICIAN'S NAME (Type) LLOYD A. HOFFMAN M.D.				22d. ADDRESS 214 N. POTOMAC ST. HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 3/17/1967		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d. LOCATION (City or Town) (County) (State) WASHINGTON D.C.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER HAGERSTOWN, MARYLAND				25a. REC'D BY REGISTRAR MAR 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

5250

Figure 1

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04293

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04295

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Norman Middle Nelson Last Heller		4. DATE OF DEATH Month March Day 25 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1917
9. AGE (In years lost birthday) yrs. 49		10. IF UNDER 1 YEAR Months 3 Days 8 Hours Min. 	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sign Painter		11b. KIND OF BUSINESS OR INDUSTRY Painting	
12. BIRTHPLACE (State or foreign country) Hagerstown, Md.		13. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. FATHER'S NAME Nelson Heller		15. MOTHER'S MAIDEN NAME Ruth Sullivan	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W. W. Two		17. SOCIAL SECURITY NO. 212-14-7245	
18. INFORMANT Mrs. E. Rebecca Heller, 115 John St.		19. ADDRESS Hagerstown, Md.	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Advanced cirrhosis of the liver			
21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23a. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		23b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
23c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		23d. (City or town) (County) (State)	
24. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Howard N. Weeks M.D.		25. DATE SIGNED 3/27/67	
EXAMINER'S NAME (Type) Howard N. Weeks, M.D.		26. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Ave. Address (Street, city, town, or county) Hagerstown, Md.	
27a. BURIAL, CREMATION, REMOVAL (Specify) Burial		27b. DATE THEREOF 3- 28- 67	
27c. NAME OF CEMETERY OR CREMATORY Benevola Cemetery		27d. LOCATION (City or Town) (County) (State) Benevola, Md.	
28. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		29. REC'D BY REGISTRAR Charles Judge	
30. REGISTRAR'S SIGNATURE Charles Judge		31. DATE MAR 29 1967	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04294 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04296

1. PLACE OF DEATH a. COUNTY WASHINGTON			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND			b. COUNTY WASHINGTON				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b LIFE			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN 21-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL						d. STREET ADDRESS 2014 GAY STREET				
3. NAME OF DECEASED (Type or print) JOHN			First Middle Last STUART HESS			4. DATE OF DEATH Month Day Year MARCH 14 1967				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT 10, 1901		9. AGE (In years last birthday) 65 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. TERMINAL MGR.				10b. KIND OF BUSINESS OR INDUSTRY TRUCKING CO.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME MAURICE HESS						14. MOTHER'S MAIDEN NAME MARGARET SCHLEIGH				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 214-10-4681		17. INFORMANT MRS. BERTIE HESS				Address 2014 GAY STREET	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Bilateral Several days DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Fracture Of Right 5th. & 6th. Ribs. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) A Possible Terminal Thrombotic Occlusion Of Anterior Descending									INTERVAL BETWEEN ONSET AND DEATH Several days	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Coronary Artery. Evidently fell in home.							
20c. TIME OF INJURY Month, Day, Year Hour a.m. Possibly 3-11- 1967			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown, Washington, Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Edward W. Ditto</i>			M.O. EDWARD W. DITTO, JR. M.D. 215 W. WASH ST			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 3-17-67	
EXAMINER'S NAME (Type) EDWARD W. DITTO, JR. M.D. 215 W. WASH ST			Address (Street, city, town, or county) HAGERSTOWN, MD.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF MARCH 18, 1967		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City, town or county) (State) HAGERSTOWN MARYLAND			
24. FUNERAL DIRECTOR CHARLES M. ROUZER			ADDRESS HAGERSTOWN, MARYLAND			25a. REC'D BY REGISTRAR MAR 21 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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WASHINGTON, D.C. 20540

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D.C. 20540

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04295

CERTIFICATE OF DEATH

04297

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Avalon Manor				d. STREET ADDRESS 1011 Oak Hill Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Harlan Hornbaker				4. DATE OF DEATH Month March Day 27 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 21, 1884		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Division Eng.		10b. KIND OF BUSINESS OR INDUSTRY W. M. Rwy. Co.		11. BIRTHPLACE (County & State, or foreign country) Mercersburg, Franklin Co U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John Hornbaker				14. MOTHER'S MAIDEN NAME Jane E. Shatzer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. A482822		17. INFORMANT Dr. John H. Hornbaker , Address 1117 Oak Hill			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Sarcoma - to stomach DUE TO (b) Retroperitoneal Lympho Sarcoma - stating the underlying cause lost. (c) 1 yr.						INTERVAL BETWEEN ONSET AND DEATH 7 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 11 , 1967, to Mar. 27 , 1967, that (I) (we) last saw the deceased alive on Mar. 27 , 1967, and that death occurred at 4 P. M, from causes and on the date stated above.							
22a. SIGNATURE Lloyd A. Hoffman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/27/67	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman				22d. ADDRESS 214 N. Pot. St. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3/28/67		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home, Inc. Hagerstown, Md.				25a. REC'D BY REGISTRAR MAR 30 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

YESNO

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04298

04298

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN Tb 5 Mon.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		10-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 504 Valley Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mildred Claire Houchin		4. DATE OF DEATH Month March Day 24 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12-1908
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY State Public Schools	
11. BIRTHPLACE (County & State, or foreign country) Fulton- Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Lewis Houchin		14. MOTHER'S MAIDEN NAME Lennie Blanche Sims	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-36-4970	
17. INFORMANT Mrs. Wm. B. Gross-304 Central Ave.		Address Brunswick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 170X Generalized Carcinomatosis IMMEDIATE CAUSE (a) Carcinoma left breast DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 10, 1966 , to March 24, 1967 , that (I) (we) last saw the deceased alive on March 24, 1967 , and that death occurred at A. M. from causes and on the date stated above.			
22a. SIGNATURE John A. Moran M.D.		22b. DATE SIGNED March 24-1967	
22c. PHYSICIAN'S NAME (Type) JOHN A. MORAN M.D.		22d. ADDRESS 215 W. Washington St., Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-28-1967	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION (City or town) (County) (State) Fulton- Missouri 65251	
24. FUNERAL DIRECTOR Elwood T. Frederick, Md. 21701		25a. REC'D BY REGISTRAR MAR 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1938

1938

STATE OF NEW YORK
IN SENATE
January 12, 1938
REPORT
OF THE
COMMISSIONER OF THE
DEPARTMENT OF
SOCIAL SERVICES
FOR THE YEAR
1937
ALBANY: J.B. LIPPINCOTT COMPANY, 1938

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04297

CERTIFICATE OF DEATH

04299

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bonsboro</u> c. LENGTH OF STAY IN 1b <u>6 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hahney-Reedy Memorial Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>1</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3601 Connecticut Ave., N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Araminta</u> First Middle Last 4. DATE OF DEATH <u>March 28</u> 19 <u>67</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 28, 1877</u> Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Berryville, Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		9. AGE (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME <u>Howell, James Franklin</u> 14. MOTHER'S MAIDEN NAME <u>Kercheval, Emma</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u> </u> Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Acute pneumonia</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4</u> <u>2 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>March 12</u> , 19 <u>67</u> , to <u>March 28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10:15 am 3-28-67</u> and that death occurred at <u>10:30 am</u> from the causes and on the date stated above. 22a. SIGNATURE <u>G.W. Lellan</u> 22c. PHYSICIAN'S NAME (Type) <u>G.W. Lellan</u> 22d. ADDRESS <u>Bonsboro Md</u>		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> 23b. DATE THEREOF <u>3-31-1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Berryville, Va.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisc. Ave. N.W., Wash. D.C.</u> 25a. REC'D BY REGISTRAR <u>MAR 31 1967</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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DATE OF BIRTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04298				CERTIFICATE OF DEATH				04300			
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN 1b <u>37 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>24 E. Salisbury Street</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> d. STREET ADDRESS <u>24 E. Salisbury St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Gladys</u> First <u>Kumler</u> Middle <u>Huddle</u> Last						4. DATE OF DEATH <u>March</u> Month <u>30</u> Day <u>1967</u> Year					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 31 1898</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR: Months <u>11</u> Days <u>29</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>David C Kumler</u>						14. MOTHER'S MAIDEN NAME <u>Myrtle Fout</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>218 30 9721B</u>		17. INFORMANT <u>24 E. Salisbury St..</u> <u>Rev. William C. Huddle Williamsport Md..</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 min?</u> <u>5 yrs</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)			
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>Nov 10</u> , 19 <u>58</u> , to <u>Mar 30</u> , 19 <u>67</u> , that (I) <u>last</u> saw the deceased alive on <u>Feb 27</u> , 19 <u>67</u> , and that death occurred at <u>12:15</u> PM from the causes and on the date stated above.											
22a. SIGNATURE <u>M. E. Byrkit</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Mar 31 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u>						22d. ADDRESS <u>Williamsport Maryland 21795</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 1-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Williamsport Maryland</u>			
24. FUNERAL DIRECTOR <u>Mr. Albert L. Leaf Williamsport Md.</u>						25a. REC'D BY REGISTRAR <u>APR 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "REPORT" and "DATE" are faintly visible.]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04299					04301				
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>4 month</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>21-1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Friendship Manor Nursing Home</u>					d. STREET ADDRESS <u>1931 Lincolnshire Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last		4. DATE OF DEATH Month Day Year							
<u>Charles William Huff</u>		<u>March 13 19 67</u>							
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 24 1903</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Buildings</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>Thomas Huff</u>			14. MOTHER'S MAIDEN NAME <u>Annie Cullison</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-9758</u>		17. INFORMANT <u>Mrs. Blanche D Huff</u>		Address <u>1931 Lincolnshire Road Hagerstown Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Arteriosclerotic Vascular Disease, Severe</u> 447X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemiplegia</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>3 years</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>6-1-</u> , 19 <u>66</u> , to <u>3-13-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-18-</u> 19 <u>67</u> , and that death occurred at <u>4 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>A. E. W. Ditto, Jr.</u>					22b. DATE SIGNED <u>3-13-67</u>				
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>					22d. ADDRESS <u>Hagerstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 15-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport Maryland</u>			
24. FUNERAL DIRECTOR <u>Albert L. Leaf</u>				ADDRESS <u>Williamsport Md.</u>		25a. REC'D BY REGISTRAR <u>16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

04303

04303

Dr. J. J. ...

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04300

CERTIFICATE OF DEATH

04302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN TB <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Wash.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Smithsburg rural</u> d. STREET ADDRESS <u>RFD #2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Simon Verdene Huntsberry</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 23, 1909</u>			
9. AGE (In years last birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pondsville, Md.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Farmer</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charles C. Huntsberry</u>				14. MOTHER'S MAIDEN NAME <u>Mrs. Onie Bear</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>214-09-9564</u>			
17. INFORMANT Address <u>Richard C. Huntsberry RD#2, Smithsburg, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO (b) <u>Phlebothrombosis</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 month</u> <u>10 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9-27, 1954</u> , to <u>3-1, 1967</u> , that (I) (we) last saw the deceased alive on <u>2-28-1967</u> , and that death occurred at <u>930 A.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles F. Hess</u>				22b. DATE SIGNED <u>3-2-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M.D.</u>				22d. ADDRESS <u>Smithsburg, Maryland 21783</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 4, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Smithsburg Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Minnich Funeral Home, Smithsburg, Md.</u>				25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE <u>MAR 6 1967</u> <u>J. Charles Judge</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAR 2 1967

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04301

CERTIFICATE OF DEATH

04303

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN TB <u>2 Weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>21-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garlock Nursing Home</u>				d. STREET ADDRESS <u>815 Antietam Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Effa</u> Middle <u>Dora</u> Last <u>Hykes</u>				4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 5, 1881</u>	
				9. AGE (In years last birthday) yrs. <u>85</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mason-Dixon Wash. Co. Md</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Shubert</u>				14. MOTHER'S MAIDEN NAME <u>Alice Boward</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>214-48-3791</u>		17. INFORMANT Address <u>Charles S. Hykes Jr. 815 Antietam Dr. Hagerstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-27, 1967</u> , to <u>3-1, 1967</u> , that (I) (we) lost saw the deceased alive on <u>2-27, 1967</u> , and that death occurred at <u>12:40 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>A M Mandell</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.M. Mandell M.D.</u>				22d. ADDRESS <u>119 East Antietam Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/3/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dunkard Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Broadforing, Wash. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Goffman Funeral Home Inc. Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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STATE OF TEXAS

02303

MAR 3 1961

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04302

CERTIFICATE OF DEATH

04304

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 year	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 316 N. Mulberry St.		d. STREET ADDRESS 316 N. Mulberry St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Grant S. Imboden		4. DATE OF DEATH Month March Day 17 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1903
9. AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter		10b. KIND OF BUSINESS OR INDUSTRY painting	
11. BIRTHPLACE (County & State, or foreign country) Annville, Pa.		12. CITIZEN OF WHAT COUNTRY? Annville, Pa.	
13. FATHER'S NAME Isaac Imboden		14. MOTHER'S MAIDEN NAME Sarah Shenk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 143-03-1091A	
17. INFORMANT Kreamer Funeral Home Annville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of rectum & metastasis DUE TO (b) metastasis DUE TO (c) metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/4 , 19 67 , to 3/17 , 19 67 , that (I) (we) last saw the deceased alive on 3/2 , 19 67 , and that death occurred at 10:30 A M, from causes and on the date stated above.			
22a. SIGNATURE Dr. George Jennings		22b. DATE SIGNED 3/17/67	
22c. PHYSICIAN'S NAME (Type) Dr. George Jennings		22d. ADDRESS Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-18-67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Annville Cemetery		23d. LOCATION (City or Town) (County) (State) Annville, Pa.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25. REGISTRAR'S SIGNATURE Charles Judge	

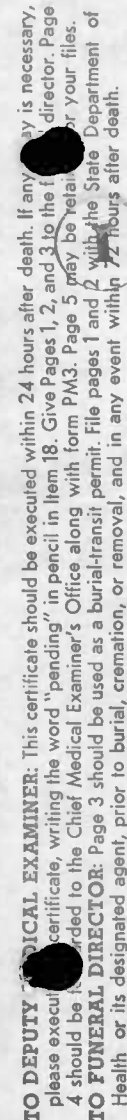
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VR A15ME
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04303

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04305

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland		c. LENGTH OF STAY IN lb 60 yrs		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 159 W. Washington Street	
3. NAME OF DECEASED (Type or print) Ashby		First (no)		Middle Jackson		Last Jackson	
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 22 1881	
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Rappahannock, Va.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Martin Jackson		14. MOTHER'S MAIDEN NAME Janie Grigsby		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 216-14-5167	
17. INFORMANT Mrs. Kathryn G. Butler		Address 38 N. Summit St. Harrisburg, Pa.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arteriosclerosis + arterio- DUE TO (c) sclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 25 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown, Md.		20g. (County) Hagerstown, Md.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE Edward W. Ditto III		EXAMINER'S NAME (Type) Edward W. Ditto III		DATE SIGNED 3-13-67		Address (Street, city, town, or county) Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-15-1967		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or country) Hagerstown, Md.	
23. FUNERAL DIRECTOR John R. Watson		ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR MAR 15 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

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MAR 1 1967

U.S. DEPARTMENT OF AGRICULTURE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04304

CERTIFICATE OF DEATH

04306

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Maryland 21-</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Maryland State Hospital</u>		d. STREET ADDRESS <u>456 Park Place</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Moll Jones</u>		4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20, 1898</u>
9. AGE (In years lost birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mill</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Rippon, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Thomas Jones</u>		14. MOTHER'S MAIDEN NAME <u>Laura Helms</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>World War I</u>		16. SOCIAL SECURITY NO. <u>217-10-3256</u>	
17. INFORMANT <u>Mrs. Hattie Jones</u>		Address <u>456 Park Place.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>1621</u> IMMEDIATE CAUSE (a) <u>carcinomatosis</u> DUE TO (b) <u>bronchogenic carcinoma</u> DUE TO (c) <u>7 mos.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-9</u> , 19 <u>67</u> to <u>3-13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 13, 1967</u> , and that death occurred at <u>6:30 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Victor L. Ramos</u>		22b. DATE SIGNED <u>March 14, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS, M.D.</u>		22d. ADDRESS <u>Western Md. State Hospital Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-18-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Md.</u>
24. FUNERAL DIRECTOR <u>John R Watson Jr. Hagerstown Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. J.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04300

March 18, 1948

Charles M. Jones

Oct. 20, 1948

Penicillium carolinense

carolinense

2 mts.

March 18, 1948

Victor L. Jones, Jr.
Blacksburg, Va.

Blacksburg, Va.
Blacksburg, Va.
Blacksburg, Va.

1-9 1948 3-13 1948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

04305

CERTIFICATE OF DEATH

04307

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 43 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 513 W. Howard St.		d. STREET ADDRESS 513 W. Howard St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLARENCE Middle SHARPE Last KARPER		4. DATE OF DEATH Month March Day 13 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1885
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner		10b. KIND OF BUSINESS OR INDUSTRY dairy business	
11. BIRTHPLACE (County & State, or foreign country) Franklin Co., Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME W. Edward Karper		14. MOTHER'S MAIDEN NAME Della Laughlin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-44-6357	
17. INFORMANT Sharpe D. Karper, Perryville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO (b) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) arteriosclerotic (Coronary) Heart Disease		INTERVAL BETWEEN ONSET AND DEATH found dead in bed - 1 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) myocardial infarction Oct 1965		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-23, 1951 , to 3-13, 1967 , that (I) (we) last saw the deceased alive on 1-23, 1967 , and that death occurred at 2:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE John H. Hornbaker, M.D.		22b. DATE SIGNED 3-13-67	
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		22d. ADDRESS 154 West Washington St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-15-67	
23c. NAME OF CEMETERY OR CREMATORY Norland Cemetery		23d. LOCATION (City or Town) (County) (State) Chambersburg, Penna.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. RECORD BY REGISTRAR MAR 16 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

02305

02305

RECEIVED

Washington

43 years

Washington

W. J. Howard

CLARENCE

STANLEY W. HARRIS

male

John J. Howard

under

Howard Howard

John J. Howard

02305-2

John J. Howard

02305-2

Howard Howard

Howard Howard

Howard Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04306

04308

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Western Maryland State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Myrtle Cleo Keefer		4. DATE OF DEATH Month March Day 20 Year 1967	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 16, 1880	
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	
11. IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>		12. CITIZEN OF WHAT COUNTRY? Williamsport, Md.	
13. FATHER'S NAME Henry Ward		14. MOTHER'S MAIDEN NAME Rebecca Keefer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Christine Hope, Mt. Rainier, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) uremia 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) nephrosclerosis DUE TO (c) arteriosclerosis, general			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 4, 1966 , to March 20, 1967 , that (I) (we) saw the deceased alive on March 20, 1967 , and that death occurred at 7:03 PM , from causes and on the date stated above			
22a. SIGNATURE Victor L. Ramos		22b. DATE SIGNED March 21, 1967	
22c. PHYSICIAN'S NAME (Type) Victor L. Ramos, M.D.		22d. ADDRESS Western Md. State Hospital, Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3-23-67	
23c. NAME OF CEMETERY OR CREMATORY Stone Bridge Breth Com.		23d. LOCATION (City or Town) (County) (State) Millstone, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR MAR 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

04308

CERTIFICATE OF DEATH

04308

Hagerstown
 Eastern Maryland State Hospital
 Hagerstown
 Washington
 Prince George's

Name: *White*
 Sex: *Male*
 Date of Birth: *Aug. 10, 1880*
 Date of Death: *March 20, 1912*
 Cause of Death: *Heart Disease*
 Physician: *Dr. J. H. ...*
 Burial Place: *St. ...*

Signature: *[Signature]*
 Registrar: *[Signature]*
 Date: *March 20, 1912*

Name: *Victor L. James, m.d.*
 Address: *St. ...*
 Date: *March 20, 1912*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04307

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04309

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 4		c. LENGTH OF STAY IN lb 11 Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 4		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Salem Church Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SAMUEL CALVIN KING Jr		4. DATE OF DEATH Month March Day 28 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23 1904
9. AGE (In years last birthday) yrs. 62		10. IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason		11b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel C. King Sr		14. MOTHER'S MAIDEN NAME Mary Ellen Springer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-09-9945	
17. INFORMANT Mrs Mary A King		Address R#4 Hagerstown Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 976X IMMEDIATE CAUSE (a) Gunshot Wound Of Head (Self Inflicted) DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot wound of head.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9 3-28- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown, Washington, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE [Signature] EXAMINER'S NAME (Type) D. E. W. Ditto, Jr.		22. DATE SIGNED 3-30-67 Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/31/67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman		25. REC'D BY REGISTRAR APR 3 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

00620

00620



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04308

CERTIFICATE OF DEATH

04310

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garlock Memorial Home			d. STREET ADDRESS 714 George St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle IRENE Last KLINE			4. DATE OF DEATH Month March Day 30 Year 1967 19		
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1 1891	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (County & State, or foreign country) Md. Westminster Carroll Co	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Jesse Fritz		
14. MOTHER'S MAIDEN NAME Valana McKane			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. 220-16-3797			17. INFORMANT Frisby S. Aline 714 George St Address Hagerstown Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 11200 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 8 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychoses</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 3/18, 1965 to 3/30, 1967, that (I) (we) last saw the deceased alive on 3/30, 1965, and that death occurred at 5:00 PM, from causes and on the date stated above.					
22a. SIGNATURE <u>Donald E. Martin</u>			22b. DATE SIGNED 3/31/67		22c. PHYSICIAN'S NAME (Type) Donald E. Martin, M.D.
22d. ADDRESS 418 N. Potomac St., Hagerstown, Md.			22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md		
24. FUNERAL DIRECTOR Hagerstown Md. Andrew K. Coffman Funeral Home Inc			25a. REC'D BY REGISTRAR APR 3 1967		
			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

00310

STATEMENT OF WORK

00310

1. Project Overview

2. Objectives

3. Scope

4. Deliverables

5. Timeline

6. Resources

7. Risks

8. Conclusion

9. Appendix

10. Notes

11. Signatures

12. Date

13. Version

14. Contact Information

15. Revision History

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04309

04311

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY WEST VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARTINSBURG		85-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DAVID		First Middle Last LEIDMAN		4. DATE OF DEATH MARCH 16		19 67	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 29, 1923	
9. AGE (In years last birthday) 43 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		11. BIRTHPLACE (State or foreign country) NEW YORK CITY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ABRAHAM LEIDMAN		14. MOTHER'S MAIDEN NAME JENNIE RESNICK		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W. 11		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT SCHWARTZ BROS., 114-03 QUEENS BLVD.		Address FOREST HILLS, NY		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull Fractured Femur lft + rgt 8164 DUE TO (b) (Crushed Chest) Multiple Lacerations of ribs DUE TO (c) Fractured		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Head on collision with oncoming car		20c. TIME OF INJURY Month, Day, Year Hour a.m. 3:13 p.m. 3-16-67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State St		20f. (City or town) Washington West Md		(County) Washington		(State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 3/16/67					
ACTUAL SIGNATURE SOL LEVINSON		EXAMINER'S NAME (Type) SOL LEVINSON		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/19/67	
23c. NAME OF CEMETERY OR CREMATORY MONTICLORE		23d. LOCATION (City or Town) SPRINGFIELD, LONG ISLAND, NY		23e. REC'D BY REGISTRAR MAR 21 1967		23f. REGISTRAR'S SIGNATURE [Signature]	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC., 6010 REIST., RD.							

04303

04303

WASHINGTON
DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF STAFF
WASHINGTON, D. C.
20315
1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04310

CERTIFICATE OF DEATH

04312

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 402 Liberty St.	
3. NAME OF DECEASED (Type or print) Fred Lee Lushbaugh		4. DATE OF DEATH Month March Day 8 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-26-14
9. AGE (In years last birthday) yrs. 52		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10b. KIND OF BUSINESS OR INDUSTRY beauty supply	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? Hagerstown, Md.	
13. FATHER'S NAME Fred Lushbaugh		14. MOTHER'S MAIDEN NAME Maude Boward	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-09-7998	
17. INFORMANT June Lushbaugh		Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism with infarction DUE TO (b) Chronic endocarditis with congestive failure DUE TO (c) Indefinite		INTERVAL BETWEEN ONSET AND DEATH 24 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1966 , to March 8, 1967 that (I) (we) last saw the deceased alive on March 8, 1967 , and that death occurred at 4:55 p.m. from causes and on the date stated above.			
22a. SIGNATURE B. B. Kneisley		22b. DATE SIGNED 3/10/67	
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22d. ADDRESS 148 West Washington St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3-11-67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home		25a. REC'D BY REGISTRAR MAR 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

06310
311

06310

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cap and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04311

CERTIFICATE OF DEATH

04313

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>25 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		21.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>122 S. Mulberry St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Catherine</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 5, 1917</u>
9. AGE (In years lost birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert E. Ruby</u>		14. MOTHER'S MAIDEN NAME <u>Grace A. Goetz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-0303</u>	
17. INFORMANT <u>C. Edgar Martin</u>		Address <u>122 S. Mulberry St. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Adeno-Carcinoma of Breast</u> DUE TO (c) <u>2 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Jan 1957</u> to <u>March 25, 1967</u> , that (1) (we) last saw the deceased alive on <u>March 24, 1967</u> and that death occurred at <u>11 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>M.E. Byrkit</u>		22b. DATE SIGNED <u>3-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>		22d. ADDRESS <u>Williamsport Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/28/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Washington, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. A. Henk</u> <u>Rest Haven Funeral Chapel</u>		25a. REC'D BY REGISTRAR <u>MAR 29 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

01110

RECEIVED IN DEPT

01110

Form with multiple sections and fields, including a large circular stamp in the center. The text is mostly illegible due to fading and bleed-through from the reverse side. Visible fragments include:

- Top left: 01110
- Top center: RECEIVED IN DEPT
- Top right: 01110
- Center: Large circular stamp with illegible text.
- Bottom: Several lines of text, including what appears to be a signature or date.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04312

CERTIFICATE OF DEATH

04314

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 8 Days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 351 Brookline Ave			
3. NAME OF DECEASED (Type or print) FREDERICK MERLE MAYHUE				4. DATE OF DEATH Month March Day 6 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 21 1905	
						9. AGE (In years last birthday) yrs. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metal Worker				10b. KIND OF BUSINESS OR INDUSTRY Fairchild Corp		11. BIRTHPLACE (County & State, or foreign country) Boonsboro Wash Co Md	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Henry W. Mayhue				14. MOTHER'S MAIDEN NAME Amanda E. Hoover			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-32-6181		17. INFORMANT Address James F. Mayhue Paradise Church Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1621 IMMEDIATE CAUSE (a) Branchogenic Carcinoma DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 19 , 19 66 , to March 6 , 19 67 , that (I) (we) last saw the deceased alive on March 6 , 19 67 , and that death occurred at 7:05 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>A.M. Mandell</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A.M. Mandell M.D.				22d. ADDRESS 119 E. Antietam St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/9/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Hagerstown Md. ADDRESS Andrew K. Coffman Funeral Home Inc				25a. REC'D BY REGISTRAR MAR 10 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and may event, within 72 hours after death.

02312

CENTRAL OF DEATH

02312

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July 10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04313

CERTIFICATE OF DEATH

04315

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HANCOCK		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RURAL HANCOCK		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALBERT WALLACE MCCUSKER		4. DATE OF DEATH MARCH 8, 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/17/1900
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		11b. KIND OF BUSINESS OR INDUSTRY FARMING	
12. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO., MD.		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME JOHN WILLIAM MCCUSKER		15. MOTHER'S MAIDEN NAME NANCY VIRGINIA BARNHART	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		17. SOCIAL SECURITY NO.	
18. INFORMANT JOHN L. MCCUSKER		Address RD. #1, HANCOCK, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Myocardial infarction DUE TO (c) Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-20 , 19 67 , to 2-21 , 19 67 ; that (I) (we) last saw the deceased alive on 2-21 , 19 67 , and that death occurred at 2-21 , 19 67 , from causes and on the date stated above.			
22a. SIGNATURE Charles R. Wierer		22b. DATE SIGNED 3-9-67	
22c. PHYSICIAN'S NAME (Type) Charles R. Wierer, M. D.		22d. ADDRESS 238 E. Main St., Hancock, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/11/67	23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET PRESBYTERIAN	23d. LOCATION (City or Town) (County) (State) RURAL HANCOCK WASH. MD.
24. FUNERAL DIRECTOR Harold J. Lane		25a. REC'D. BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 14 1967	

06315

CERTIFICATE OF DEATH

06315

WASHINGTON

MARYLAND

WASHINGTON

RURAL HANDOK

LIFE

RURAL HANDOK

RURAL HANDOK

RURAL HANDOK

MARCH

WILLIAM

ALBERT

52

FARMING

WHITE

MALE

U.S.A.

WASHINGTON DC. U.S.A.

FARMING

FARMING

NANCY VIRGINIA BARNHART

JOHN WILLIAM HOOKER

JOHN L. HOOKER, JR. 11. HANDOK, MD.

10

RURAL HANDOK		WILLIAM		ALBERT	
LIFE		FARMING		WHITE	
MARCH		52		MALE	
WASHINGTON DC. U.S.A.		FARMING		FARMING	
NANCY VIRGINIA BARNHART		JOHN WILLIAM HOOKER		JOHN L. HOOKER, JR. 11. HANDOK, MD.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04314						04317					
1. PLACE OF DEATH e. COUNTY <u>Washington</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Boonsboro, Md.</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pachoney-Keedy Memorial Home</u>						d. STREET ADDRESS <u>16 North Mulberry Street</u>					
3. NAME OF DECEASED (Type or print) <u>Ora</u>						4. DATE OF DEATH <u>3 15 1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/2/1876</u>		9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife & Sew</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>F. Beachley</u>						14. MOTHER'S MAIDEN NAME <u>Caroline</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-16-0538</u>		17. INFORMANT <u>D.R. Beachley Sr.</u> Address <u>227 N. Prospect St. Hagerstown, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis cardio vascular</u> 41221 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Disease</u> (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 4 1967</u> to <u>March 15 1967</u> that (I) (we) last saw the deceased alive on <u>March 15 1967</u> , and that death occurred at <u>12 noon</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>G. W. LeVan</u>						22b. DATE SIGNED <u>March 15 1967</u>					
22c. PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>						22d. ADDRESS <u>Boonsboro, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3/18/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Church Of Brethern Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Beaver Creek, Washington, Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Hart</u>						25a. REC'D BY REGISTRAR <u>MAR 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04315

CERTIFICATE OF DEATH

04316

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HANCOCK	
c. LENGTH OF STAY IN 1b 3 WKS		d. STREET ADDRESS W.MAIN ST.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARGARETTA RUTH MCKINLEY		4. DATE OF DEATH Month 3 Day 18 Year 19 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5.26.1908
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) HANCOCK MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN W WHORTON		14. MOTHER'S MAIDEN NAME BEULAH BARNHART	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220.26.0632	
17. INFORMANT A HART MCKINLEY		Address MD. W.MAIN ST. HANCOCK	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast with Metastases 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 19 62 to 3-18 19 67, that (I) (we) last saw the deceased alive on 3-18 19 67, and that death occurred at 4:35 P.M. from causes and on the date stated above.			
22a. SIGNATURE Dalton M. Welty		22b. DATE SIGNED 3/20/67	
22c. PHYSICIAN'S NAME (Type) Dalton M. Welty, M.D.		22d. ADDRESS 998 Potomac Ave., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3.21.67	23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET	23d. LOCATION (City or Town) (County) (State) RURAL HANCOCK WASHINGTON
24. FUNERAL DIRECTOR Howard F. Elmore		25a. REC'D BY REGISTRAR MAR 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		MD.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04316

04316

WASHINGTON

WASHINGTON

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WASHINGTON

WASHINGTON COURT REPORTER

WASHINGTON COURT REPORTER

MARGARETTA RUTH MORRIS

MARGARETTA RUTH MORRIS

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HANCOCK HAYLAND

HANCOCK HAYLAND

GENERAL MANAGER

GENERAL MANAGER

220.25.0032 2 HART MORRIS 2.25.1008

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04318

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Williamsport d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital D. O. A		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Williamsport d. STREET ADDRESS Mt. Tammany e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Raymond Hershey Miller Jr. 4. DATE OF DEATH March 17 1967		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Dec. 23 1922 9. AGE (In years last birthday) 44 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Business Manager 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY U.S.A	
13. FATHER'S NAME Raymond H. Miller Sr. 14. MOTHER'S MAIDEN NAME Edna Ankeney		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes World War #2 16. SOCIAL SECURITY NO. 220 16 0307 17. INFORMANT Mt. Tammany Mrs. Marion Miller Williamsport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture Cervical Vertebra (c) Fracture Right Femur (d) Compound Fracture Right Elbow PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car struck bridge abutment.	
20c. TIME OF INJURY Month, Day, Year Hour 8:35 p.m. 3-17- 19 67 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U. S. 81 20f. (City or town) Hagerstown, Washington, Md. (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr. EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3-18-67 Address (Street, city, town, or county) Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF March 20-67 22c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery 22d. LOCATION (City, town, or county) Hagerstown Md. (State)		23. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Md. ADDRESS 24a. REC'D BY REGISTRAR MAR 22 1967 24b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04317

CERTIFICATE OF DEATH

04319

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN TB 46 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 1030 Main Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Daniel Middle Ellsworth Last Montgomery		4. DATE OF DEATH Month March Day 28 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26 1902
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Cabinet Shop		10b. KIND OF BUSINESS OR INDUSTRY Organ Mfg.	
11. BIRTHPLACE (County & State, or foreign country) Keedysville Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME John F. Montgomery		14. MOTHER'S MAIDEN NAME Nannie F. Wade	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-2401	
17. INFORMANT Mrs. Grace Montgomery		Address Hagerstown	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Endotoxic shock DUE TO (b) acute pyelonephritis DUE TO (c) arteriosclerotic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 6000		INTERVAL BETWEEN ONSET AND DEATH sudden sev. days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic nephrosclerosis & pyelonephritis; C.V.D.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 1960 to March 1967 , that (I) (we) last saw the deceased alive on March 28, 1967 , and that death occurred at 5 A M, from causes and on the date stated above.			
22a. SIGNATURE Howard N. Weeks		22b. DATE SIGNED 3/28/67	
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		22d. ADDRESS 580 Northern Avenue Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-31-1967	
23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION (City or Town) (County) (State) Smithsburg, Maryland	
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.		25a. REC'D BY REGISTRAR APR 3 1967	
25b. REGISTRAR'S SIGNATURE Charles J. [Signature]			

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04318

CERTIFICATE OF DEATH

04320

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 Weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NANNIE PEARL MOSER-LUSHBAUGH</u>		4. DATE OF DEATH Month Day Year <u>March 27 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb'y 15 1885</u>
9. AGE (In years last birthday) yrs. <u>82</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Church Hill Fred Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Soule J. Warrenfeltz</u>		14. MOTHER'S MAIDEN NAME <u>Clara Palmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-46-6139</u>	
17. INFORMANT <u>Lester Lushbaugh</u>		Address <u>1 West Wilson Blvd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>athrosclerotic heart disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>January, 1958</u> , to <u>March, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 26 1967</u> , and that death occurred at <u></u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Howard N. Weeks</u> M.D.		22b. DATE SIGNED <u>3/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		22d. ADDRESS <u>580 Northern Avenue Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/30/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash Co Md</u>
24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>		25a. REC'D BY REGISTRAR <u>MAR 30 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

08380

REPORT OF WORK

08380

1. TITLE

2. SUMMARY

3. OBJECTIVES

4. METHODS

5. RESULTS

6. CONCLUSIONS

7. REFERENCES

8. DISTRIBUTION

9. COMMENTS

10. APPENDICES

11. BIBLIOGRAPHY

12. GLOSSARY

13. INDEX

14. ACKNOWLEDGMENTS

15. CURRICULUM VITAE

16. PHOTOGRAPHS

17. MAPS

18. OTHER

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04319

CERTIFICATE OF DEATH

04321

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HANCOCK 21.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS RURAL 1	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES SIMMONS MUNSON		4. DATE OF DEATH Month Day Year 3 19 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 8 1880
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) HANCOCK MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN W MUNSON		14. MOTHER'S MAIDEN NAME PLESANT SOMMONS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT NORMAN R MUNSON		Address RURAL 1 HANCOCK MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pulmonary embolism DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 hours 8 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) urinary tract infection severe		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-25 , 19 66 , to 3-19 , 19 67 , that (I) (we) last saw the deceased alive on 3-19 19 67 , and that death occurred at 6 P M, from causes and on the date stated above.			
22a. SIGNATURE Joseph C. Crisp		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOSEPH C. CRISP		22d. ADDRESS 580 Northern Ave Hagerstown	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3.23.67	
23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		23d. LOCATION (City or Town) (County) (State) RURAL 1 HANCOCK WASHINGTON MD.	
24. FUNERAL DIRECTOR Hausel & Sons Hagerstown Md		25a. REC'D BY REGISTRAR MAR 27 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J...			

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STATE OF MICHIGAN

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural 1, Clear Spring d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rural 1.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural 1 d. STREET ADDRESS Clear Spring, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ralph Franklin Myers				4. DATE OF DEATH Month Day Year March 12 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/23/21	
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days 46		11. IF UNDER 24 HRS. Hours Min. 46		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Wash. Co. Md.	
13. FATHER'S NAME James Myers				14. MOTHER'S MAIDEN NAME Mazie Shank			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W W 2				16. SOCIAL SECURITY NO. 215-26-1849			
17. INFORMANT Mrs Genevieve Myers, Route 1, Clspg,				Address Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Penetrating gunshot wound of 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) chest (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1-10 Hm						INTERVAL BETWEEN ONSET AND DEATH 1-10 Hm	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot of chest	
20c. TIME OF INJURY Month, Day, Year 3-12-1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Clear Spring Wash. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Edward W. Ditto III				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Edward W. Ditto III				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 3-14-67			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/15/67		22c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Memorial Park	
				22d. LOCATION (City, town, or county) (State) Hagerstown, Md.			
23. FUNERAL DIRECTOR Margaret Rawland				ADDRESS Clear Spring, Md.		24a. REC'D BY REGISTRAR Charles Judge	
				DATE 16 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

04321

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04323

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN b 1 1/2 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown rural		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS RFD 6	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle FRANK Last PENNINGTON		4. DATE OF DEATH Month March Day 8 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-24-1912
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plastics dept.		10b. KIND OF BUSINESS OR INDUSTRY aircraft mfg.	
11. BIRTHPLACE (State or foreign country) Jefferson Co., W.Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank B. Pennington		14. MOTHER'S MAIDEN NAME Emma V. Collis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 232-28-2688	
17. INFORMANT Mrs. Kathryn Pennington, Hag., Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 330 X IMMEDIATE CAUSE (a) Ruptured berry aneurysm of left middle cerebral artery DUE TO Intracerebral hemorrhage of temporal lobe and insula on left side (b) Massive subarachnoid hemorrhage 2ndary DUE TO hemorrhage into midbrain (c) Coronary atherosclerosis with old myocardial infarction. Cardiac hypertrophy		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary atherosclerosis with old myocardial infarction. Cardiac hypertrophy		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in driveway at home - Struck Head	
20c. TIME OF INJURY Month, Day, Year Hour 4:45 am. 3-6-1967 p.m.		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Morgansville Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III M.D.		22. DATE SIGNED 3-8-67	
EXAMINER'S NAME (Type) DR. EDWARD E. DITTO III 217 W. WASHINGTON ST. HAG., MD.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-11-67	23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery	23d. LOCATION (City or Town) (County) (State) Shepherdstown, W.Va.
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR MAR 13 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

04334

04331

Washington

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DR. EDWARD E. OTTO III
117 W. WASHINGTON ST. HAR... MD.

Washington County, New York

Washington County, New York

Washington County, New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04322

04324

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>21 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>132 Dogwood Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Agnes</u> Last <u>Pittinger</u>		4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Sept. 8, 1884</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Jarrytown, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dennis Bannon</u>		14. MOTHER'S MAIDEN NAME <u>Catherine O'Connor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>074-22-57957</u>	
17. INFORMANT <u>Mrs. Margaret Reif</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> (c) <u>Generalized atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 wks</u> <u>unk</u> <u>unk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Seven month dementia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 2, 1967</u> , to <u>Mar 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar 14, 1967</u> , and that death occurred at <u>3:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>L. L. Packer Jr</u>		22b. DATE SIGNED <u>3/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. L. Packer Jr MD</u>		22d. ADDRESS <u>Hagerstown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/16/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Washington, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. A. Hark</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
26. DATE <u>MAR 16 1967</u>		27. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04323

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04325

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsport	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 114 W. Salisbury Street	
3. NAME OF DECEASED (Type or print) Alice Hoffman Poole		4. DATE OF DEATH March 31 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 10 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (In years last birthday) 55 yrs.
13. FATHER'S NAME Charles G. Poole		14. MOTHER'S MAIDEN NAME Sadie Elizabeth Crowell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220 18 1047	
17. INFORMANT Mr. David K. Poole Jr.		138 W. Address Washington St. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 6000 DUE TO Hypercalcemia incidental to (b) anemia due chronic (c) pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3-6 days 5-10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto III Hagerstown, Maryland		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 3-67	
22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Maryland	
23. FUNERAL DIRECTOR ADDRESS Albert L. Leaf Williamsport Maryland		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Charles Judge	

APR 1 1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04324

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence or Admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 45 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Percy Middle Joseph Last Potter		4. DATE OF DEATH Month March Day 4 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-17-1879
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) vice president		11b. KIND OF BUSINESS OR INDUSTRY sand blast mfg.	
11. BIRTHPLACE (County & State, or foreign country) Stratford on Avon Eng.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick K. Potter		14. MOTHER'S MAIDEN NAME Susan A. Rutter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-09-6087	
17. INFORMANT Mary Potter		Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism with infarction DUE TO (b) Thrombosis right iliac vein DUE TO (c) Indefinite Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 466X		INTERVAL BETWEEN ONSET AND DEATH 12 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic heart disease with auricular fibrillation and heart block			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from Feb. 21 , 19 67 , to March 4 , 19 67 that (2) (we) last saw the deceased alive on March 3 , 19 67 , and that death occurred at 5:15 A. M, from causes and on the date stated above.			
22a. SIGNATURE B. B. Kneisley		22b. DATE SIGNED 3/6/67	
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22d. ADDRESS 148 West Washington St. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 3-6-67	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.		25a. REC'D BY REGISTRAR MAR 9 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

04334

04334

GRAND JURY

1964

State of New York
County of New York
In and for the City and County of New York
The People of the State of New York, by and through the Grand Jury thereof, do hereby certify that the following is a true and correct copy of the report of the Grand Jury made to the Court at the session of the Court held on the 1st day of January, 1964.

Report of the Grand Jury
made to the Court at the session of the Court held on the 1st day of January, 1964.

The Grand Jury, composed of the following members, do hereby certify that the following is a true and correct copy of the report of the Grand Jury made to the Court at the session of the Court held on the 1st day of January, 1964.

The Grand Jury, composed of the following members, do hereby certify that the following is a true and correct copy of the report of the Grand Jury made to the Court at the session of the Court held on the 1st day of January, 1964.

The Grand Jury, composed of the following members, do hereby certify that the following is a true and correct copy of the report of the Grand Jury made to the Court at the session of the Court held on the 1st day of January, 1964.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04325

CERTIFICATE OF DEATH

04327

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>State</u> <u>Hosp.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cal.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland - Md</u> <u>04-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Maryland State Hosp.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> <u>R</u> <u>Reed</u>				4. DATE OF DEATH Month <u>3</u> Day <u>27</u> Year <u>1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-3-1900</u>	
9. AGE (In years last birthday) yrs. <u>66</u>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Dennis Reed</u>				14. MOTHER'S MAIDEN NAME <u>Christine Thomas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-12-9241</u>		17. INFORMANT <u>Lionia Reed</u> Address <u>Friendship AA. Co.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Lobar pneumonia</u> DUE TO (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Arteriosclerosis, General</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>332X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>25 days</u> <u>4 years</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>pyelonephritis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-9</u> , 19 <u>66</u> , to <u>3-27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-26</u> 19 <u>67</u> , and that death occurred at <u>5:30</u> AM, from causes and on the date stated above							
22a. SIGNATURE <u>Mayesville</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>3-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>NEVARDO LAYZECUILLA</u>				22d. ADDRESS <u>1500 PENNA. AVE. HAGERSTOWN, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3-31-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Ch. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Sunderland Cal. Md</u>	
24. FUNERAL DIRECTOR <u>Pinney E. Sewell</u>				ADDRESS <u>Pinney E. Sewell</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

04357

CHRONICLE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04326

CERTIFICATE OF DEATH

04328

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u> c. LENGTH OF STAY IN 1b <u>2 Years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Reeder Nursing Home</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>620 Chestnut St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Elizabeth</u> Last <u>Reeder</u>			4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>19 67</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1870</u>	9. AGE (In years lost birthday) <u>96</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>15</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>Lewis Shank</u>		
14. MOTHER'S MAIDEN NAME <u>Ella Alexander</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		
16. SOCIAL SECURITY NO. <u>220-52-2108</u>			17. INFORMANT <u>726 Maryland Ave.</u> <u>Mrs. Goldie Henninger, Hagerstown, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interoskeletal cardio vascular</u> DUE TO (b) <u>disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 4</u> , 19 <u>67</u> , to <u>March 14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 14</u> , 19 <u>67</u> , and that death occurred at <u>1 P.</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>G. W. LeVan</u>			22b. DATE SIGNED <u>March 15, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>			22d. ADDRESS <u>Boonsboro, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3-17-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Locust Grove Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Locust Grove, Md.</u>	
24. FUNERAL DIRECTOR <u>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</u>			25. REGISTERED BY REGISTRAR <u>MAR 21 1967</u> DATE		
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04327

CERTIFICATE OF DEATH

04329

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 13 Hours			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				d. STREET ADDRESS 231 South Locust St.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN WILLIAM REMSBURG Sr				4. DATE OF DEATH Month Day Year March 28 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 27 1886	
				9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. PLACE (County & State, or foreign country) Chewsville Wash Co Md	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Joseph H. Remsburg				14. MOTHER'S MAIDEN NAME Sarah E. Young			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-14-9819		17. INFORMANT Clayton I. Remsburg Address Frederick Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 advanced atherosclerosis DUE TO (b) dehydration - cachexia DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 7/20 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hosp. Inc		20f. (City or town) (County) (State) Hagerstown Wash. Md.	
21. I certify that (I) (this hospital) attended the deceased from 3/20 , 19 67 , to 3/28 , 19 67 , and that death occurred at 4 P M, from causes and on the date stated above.							
22a. SIGNATURE A. M. Mandell				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. /DATE SIGNED 3/30/67	
22c. PHYSICIAN'S NAME (Type) A. M. MANDELL, M.D.				22d. ADDRESS 119 E. Antietam St.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/31/67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman Hagerstown Md. ADDRESS Funeral Home Inc				25a. REC'D BY REGISTRAR DATE APR 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04328 CERTIFICATE OF DEATH 04330

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN ID 1 week			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital			e. STREET ADDRESS Downsville Pike		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Edith Middle May Last Renner			4. DATE OF DEATH Month March Day 17 Year 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4 1910	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months 5 Days 12 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A			13. FATHER'S NAME Charles Rickard		
14. MOTHER'S MAIDEN NAME Rose Myers			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. None			17. INFORMANT Mr. Willis Renner Williamsport Md. RFD 1		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X COCAINE of Uterus & the Fallopian Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1967
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition, Emphysema					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 6-6-60, 19, to 3-17-1967, that (I) (we) last saw the deceased alive on 3-16-1967, and that death occurred at 1:02 P.M. from the causes and on the date stated above.					
22a. SIGNATURE E. R. Lardizabal, M. D.			22b. DATE SIGNED 3-17-67		
22c. PHYSICIAN'S NAME (Type) E. R. LARDIZABAL, M. D.			22d. ADDRESS 300 NORTH POTOMAC ST. HAGERSTOWN, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 19-67		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	
23d. LOCATION (City, town or county) Williamsport Maryland		(State)			
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Md.			25a. REC'D BY REGISTRAR MAR 21 1967		
25b. REGISTRAR'S SIGNATURE Charles Judge					

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04329

CERTIFICATE OF DEATH

04331

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN b 43 YEARS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN 21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 136 N. POTOMAC STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NORMA NMI RIGGIN				4. DATE OF DEATH Month Day Year MARCH 30 19 67			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 9 1894		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REGISTERED NURSE		10b. KIND OF BUSINESS OR INDUSTRY MEDICINE		11. BIRTHPLACE (County & State, or foreign country) FLINT HILL VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWIN RAMEY				14. MOTHER'S MAIDEN NAME ALBENIA PAYNE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-46-8891		17. INFORMANT WILLIAM C RIGGIN HAGERSTOWN MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia & uremia DUE TO (b) Generalized metastasis DUE TO (c) Adenocarcinoma of stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 1 mo 6 wks 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that (I) (this hospital) attended the deceased from Sept 19 61 , to Mar 30 19 67 , that (I) (we) last saw the deceased alive on Mar 30 19 67 , and that death occurred at 3 AM , from causes and on the date stated above.							
22a. SIGNATURE <i>H.R. Tritch Jr M.D.</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/31/67	
22c. PHYSICIAN'S NAME (Type) H.R. TRITCH JR. M. D.				22d. ADDRESS 302 N. POTOMAC ST. HAGERSTOWN MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/1/67		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASHINGTON MD.	
24. FUNERAL DIRECTOR CHARLES M ROUZER HAGERSTOWN MARYLAND				25a. REC'D BY REGISTRAR APR 5 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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APR 8 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04330

CERTIFICATE OF DEATH

04332

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN TB 5 Hrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS oller Apts	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY ALBERTA RITCHIE		4. DATE OF DEATH March 3 1967	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 7 1870	
9. AGE (In years last birthday) 96		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Purcellville Loudon Co Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Alder		14. MOTHER'S MAIDEN NAME Hannah Myers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Mary Helen James Moller Apts		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4200 IMMEDIATE CAUSE (a) Congestive heart failure DUE TO arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH ? several weeks unknown.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obstructive jaundice - cause unknown -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-3, 1967 , to 3-3, 1967 , that (I) (we) last saw the deceased alive on 3-3 1967 , and that death occurred at 11 P.M. from causes and on the date stated above.			
22a. SIGNATURE John H. Hornbaker, M.D.		22b. DATE SIGNED 3-4-67	
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		22d. ADDRESS 154 W. Washington St. Hagerstown, Md. 21740	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/6/67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman		25a. REC'D BY REGISTRAR MAR 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

06330

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MINUTE OF MEETING

MINUTE OF MEETING OF THE BOARD OF DIRECTORS OF THE
UNITED STATES DEPARTMENT OF AGRICULTURE
HOLDING COMPANY, INC. - AGRICULTURAL HOLDING COMPANY, INC.

MEMORANDUM

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04331

CERTIFICATE OF DEATH

04333

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN lb 20 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CLEARSRING 21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS RT. #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RICHARD VIRL ROBINSON				4. DATE OF DEATH Month Day Year MARCH 2 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/19/1913		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY MACHINE EQUIP. CORP.		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID FILMORE ROBINSON				14. MOTHER'S MAIDEN NAME MARY FAITH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-16-0139		17. INFORMANT Address MRS. EDNA M. ROBINSON RT. #1 MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal bilateral lobular pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic hepatic cirrhosis Laennec type with ascites DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days Known 2 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 29 , 19 66 , to March 2 , 19 67 that (I) (we) lost saw the deceased alive on March 1 , 1967, and that death occurred at 3:30 A. M, from causes and on the date stated above.							
22a. SIGNATURE <i>B. B. Kneisley</i>				22b. DATE SIGNED 3/3/67		22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.	
22d. ADDRESS 148 West Washington St. Hagerstown, Maryland							
23a. BURIAL, CREMATION, REMAINS (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		3/4/67		MT. VIEW CEM.		RINGOLD WASH. MD.	
24. FUNERAL DIRECTOR <i>W. J. Normant Hagerstown, Md.</i>				25a. REC'D BY REGISTRAR DATE MAR 6 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

04333

04333

WASHINGTON COUNTY HOSPITAL
WASHINGTON
TO DIRECTOR
RE: [illegible]

WASHINGTON COUNTY HOSPITAL
WASHINGTON
TO DIRECTOR
RE: [illegible]

WASHINGTON COUNTY HOSPITAL
WASHINGTON
TO DIRECTOR
RE: [illegible]

WASHINGTON COUNTY HOSPITAL
WASHINGTON
TO DIRECTOR
RE: [illegible]

WASHINGTON COUNTY HOSPITAL
WASHINGTON
TO DIRECTOR
RE: [illegible]

WASHINGTON COUNTY HOSPITAL
WASHINGTON
TO DIRECTOR
RE: [illegible]

WASHINGTON COUNTY HOSPITAL
WASHINGTON
TO DIRECTOR
RE: [illegible]

WASHINGTON COUNTY HOSPITAL
WASHINGTON
TO DIRECTOR
RE: [illegible]

WASHINGTON COUNTY HOSPITAL
WASHINGTON
TO DIRECTOR
RE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04332

CERTIFICATE OF DEATH

04334

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 47 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 15 CYPRESS STREET		d. STREET ADDRESS 15 CYPRESS STREET	
3. NAME OF DECEASED (Type or print) First JOHNNIE Middle McCULLEN Last ROE		4. DATE OF DEATH Month MARCH Day 5 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 24, 1894
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY DOOR MFG.	
11. BIRTHPLACE (County & State, or foreign country) TALBOT CO., MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES A. ROE		14. MOTHER'S MAIDEN NAME CLARA STUPES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-09-5886	
17. INFORMANT MRS. RUTH ROE		18. ADDRESS 15 CYPRESS STREET HAGERSTOWN, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Extensive coronary artery disease DUE TO (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH unknown years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 19 65 , to 5 March, 1967 , that (I) (we) last saw the deceased alive on 26 Feby 1967 , and that death occurred at 19 00 M, from causes and on the date stated above.			
22a. SIGNATURE John C. Stauffer		22b. DATE SIGNED 3/7/1967	
22c. PHYSICIAN'S NAME (Type) JOHN C. STAUFFER M.D.		22d. ADDRESS 145 S. PROSPECT ST. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MARCH 8, 1967	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, MARYLAND
24. FUNERAL DIRECTOR CHARLES M. ROUZER		ADDRESS HAGERSTOWN, MARYLAND	
25a. REC'D BY REGISTRAR MAR 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

00332

00332

RECEIVED

17 OCT 1964

17 OCT 1964

FROM: SAC, NEW YORK

TO: DIRECTOR

RE: MURDER OF MARTIN LUTHER KING, JR.

RE: NEW YORK TELETYPE TO BUREAU, OCTOBER 16, 1964.

RE: NEW YORK TELETYPE TO BUREAU, OCTOBER 16, 1964.

FOR INFORMATION OF THE BUREAU, THE NEW YORK OFFICE IS CURRENTLY CONDUCTING AN INVESTIGATION OF THE ALLEGED ATTEMPT TO OBTAIN A PASSPORT FOR THE SUBJECT OF THE ABOVE MENTIONED CASE.

THE NEW YORK OFFICE IS CURRENTLY CONDUCTING AN INVESTIGATION OF THE ALLEGED ATTEMPT TO OBTAIN A PASSPORT FOR THE SUBJECT OF THE ABOVE MENTIONED CASE.

THE NEW YORK OFFICE IS CURRENTLY CONDUCTING AN INVESTIGATION OF THE ALLEGED ATTEMPT TO OBTAIN A PASSPORT FOR THE SUBJECT OF THE ABOVE MENTIONED CASE.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04333 CERTIFICATE OF DEATH 04333

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsport c. LENGTH OF STAY IN 1b 1 month-3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Williamsport Sanitarium		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 22 Elizabeth Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rosie Middle May Last Romesburg		4. DATE OF DEATH Month March Day 3 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House duties		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Pleasant Valley, Maryland
13. FATHER'S NAME Wesley Marshall		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Melvin E. Ashton-Martinsburg, West Virginia		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arrhythmia of uncertain cause DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH months unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January, 1967 , to March, 1967 , that (I) (we) last saw the deceased alive on March 1, 1967 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Charles J. Jones		22b. DATE SIGNED MAR 13 1967	
22c. PHYSICIAN'S NAME (Type) Charles J. Jones		22d. ADDRESS M.D. PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-5-1967	23c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery	23d. LOCATION (City, town or county) (State) Martinsburg, Berkeley, W. Va.
24. FUNERAL DIRECTOR Brown Funeral Home		25a. REC'D BY REGISTRAR Charles J. Jones	
25b. REGISTRAR'S SIGNATURE Charles J. Jones		DATE MAR 13 1967	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04334

04336

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Western Maryland State Hosp.				d. STREET ADDRESS 418 Fremont St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret Leucritia Ross		First Middle Last		4. DATE OF DEATH March 1, 1967		Month Day Year	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH June 20, 1917	
9. AGE (In years lost birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Pa. Myersdale Somerset Co		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		13. FATHER'S NAME Calvin Holiday		14. MOTHER'S MAIDEN NAME Clara C. Hatton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, up, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Lester W. Ross		Address 418 Fremont St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinoma of cervix</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		Hagerstown Md.		INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (1) (this hospital) attended the deceased from 1-16-67, 1967, to 3-1, 1967, that (1) (we) last saw the deceased alive on 2-28 1967, and that death occurred at 1A M, from causes and on the date stated above.			
22a. SIGNATURE Victor L. Ramos, M.D.		22b. DATE SIGNED March 1, 1967		22c. PHYSICIAN'S NAME (Type) Victor L. Ramos, M.D.		22d. ADDRESS Western Md. State Hospital Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/4/67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Mdo	
24. FUNERAL DIRECTOR Andrew K. Coffman		Hagerstown Md		25a. REC'D BY REGISTRAR DATE MAR 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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STATE OF TEXAS

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Marshall University
June 1917
March 17

Continuation of series
1917

Victor L. Francis, M.D.
Director & General
Hospitals, Texas
X Marks 1917
1-16-17 3-1-17 5-1-17
6-1-17

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04335

CERTIFICATE OF DEATH

04337

1. PLACE OF DEATH a. COUNTY Washington Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Hagerstown Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chambersburg 17201	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 236 Lincoln Way East	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dr. Lewis Middle H. Last Seaton		4. DATE OF DEATH Month March Day 21st. Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 30th. 1885
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR Months 17 Days 5 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Dr.	
11. BIRTHPLACE (County & State, or foreign country) Uniontown Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis M. Seaton		14. MOTHER'S MAIDEN NAME Julia Stacy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) 1st W. War		16. SOCIAL SECURITY NO. 179-36-3418	
17. INFORMANT Dr. Lewis H. Seaton		17500 McDade Court 2nd. Derwood Md. -20855	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Hypertensive Cardiovasc. Disease DUE TO (c) Arteriosclerosis - Generalized			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Vess. Arteriosclerotic Disease - senility			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 2, 1966 , to Mar. 21, 1967 , that (I) (we) last saw the deceased alive on March 21, 1967 , and that death occurred at 5:30 A.M. from causes on and on the date stated above.			
22a. SIGNATURE Lloyd A. Hoffman		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		22d. ADDRESS 214 N. Pot-st. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/23/1967	23c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Chambersburg - Franklin-Pa.
24. FUNERAL DIRECTOR Sellers Funeral Home Chambersburg Penna.		25a. REC'D BY REGISTRAR MAR 23 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

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00331

STANDARD FORM NO. 64

00331

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04336

04338

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> COUNTY <u>Washington</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN TB <u>15 Hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R#6</u> <i>21-1</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>Salem Church Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>SAMUEL CALVIN SECRIST</u> First Middle Last				4. DATE OF DEATH <u>March 8 1967</u> Month Day Year				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 28 1880</u>		
				9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days		
						IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Sylvan Franklin Co Pa.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Abraham Secrist</u>				14. MOTHER'S MAIDEN NAME <u>Susan Zimmerman</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>David P. Secrist Hagerstown Md R #2</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>not known</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Gastro-Intestinal Bleeding - Cause not known</u>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>3-7, 1967</u> to <u>3-8, 1967</u> that (I) (we) last saw the deceased alive on <u>3-7, 1967</u> and that death occurred at <u>7:45 PM</u> from causes and on the date stated above.								
22a. SIGNATURE <u>Arthur Riego</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>3/8/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR RIEGO</u>				22d. ADDRESS <u>159 W. Washington St.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/11/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lutheren Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Sylvan Franklin Co Pa</u>		
24. FUNERAL DIRECTOR <u>Hagerstown Md.</u> <u>Andrew K. Coffman</u>				25a. RECEIVED BY REGISTRAR <u>Home Inc</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECORDS OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04337

CERTIFICATE OF DEATH

04339

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILLIAMSPORT		c. LENGTH OF STAY IN 1b 45 YRS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILLIAMSPORT		d. STREET ADDRESS 23 W. CHURCH ST.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle HORINE Last SHANK		4. DATE OF DEATH Month 3 Day 28 Year 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3.2.1895
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERINTENDANT TEXTILE MILLS	11. BIRTHPLACE (County & State, or foreign country) FREDERICK COUNTY MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE SHANK	
14. MOTHER'S MAIDEN NAME ESTA HORINE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT ANNIE A SHANK 23 W. CHURCH WILLIAMSPORT MD. T	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) 10 yrs (c) 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) No		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Williamsport		20f. (City or town) (County) (State) Williamsport Maryland	
21. I certify that I (this hospital) attended the deceased from November 25 19 60 , to Feb. 9 , 19 67 , that (I) (we) last saw the deceased alive on Feb. 9 , 19 67 , and that death occurred at 5:30 M, from causes and on the date stated above.			
22a. SIGNATURE M. E. Byrkit		22b. DATE SIGNED March 30, 1967	
22c. PHYSICIAN'S NAME (Type) M. E. Byrkit		22d. ADDRESS 28 West Potomac Street, Williamsport	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3.31.67	
23c. NAME OF CEMETERY OR CREMATOR ST. PAUL		23d. LOCATION (City or Town) (County) (State) RURAL CLEARSPRING WASH. MD	
24. FUNERAL DIRECTOR Howard & Howe Williamsport md		25a. REC'D BY REGISTRAR APR 3 1967	
25b. REGISTRAR'S SIGNATURE James J. Judge		25c. REGISTRAR'S NAME James J. Judge	

04339

STATE OF NEW YORK

04339

WASHINGTON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04338

CERTIFICATE OF DEATH

04340

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 3 MOS.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS LEITERSBURG PIKE	
e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALBERT Middle BERLEY Last SHEALY		4. DATE OF DEATH Month MARCH Day 7 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 20, 1900
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SCHOOL TEACHER		10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOL	
11. BIRTHPLACE (County & State, or foreign country) NEWBERRY CO., S. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NOAH E. SHEALY		14. MOTHER'S MAIDEN NAME JANE CHAPMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 456-03-5034	
17. INFORMANT MRS. KATHERINE SHEALY		HAGERSTOWN, MARYLAND LEITERSBURG PIKE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO (b) Acute Coronary Occlusion DUE TO (c) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 5 min Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 3, 1967 , to March 7, 1967 that (I) (we) last saw the deceased alive on March 7, 1967 , and that death occurred at 12:00 PM , from causes and on the date stated above.			
22a. SIGNATURE Lawrence L. Packer, Jr.		22b. DATE SIGNED 3/7/1967	
22c. PHYSICIAN'S NAME (Type) LAWRENCE L. PACKER, JR. M.D.		22d. ADDRESS 145 W. WASHINGTON ST. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 3/7/1967	
23c. NAME OF CEMETERY OR CREMATORY GRAND VIEW MEM. PARK CEM.		23d. LOCATION (City or Town) (County) (State) ROCK HILL S. CAROLINA	
24. FUNERAL DIRECTOR CHARLES M. ROUZER		ADDRESS HAGERSTOWN, MARYLAND	
25a. REC'D BY REGISTRAR MAR 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04339

CERTIFICATE OF DEATH

04341

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Keedysville</u>		c. LENGTH OF STAY IN 1b <u>26 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Keedysville</u> <u>21-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rfd. 1</u>			d. STREET ADDRESS <u>Rfd. 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Blanche Estelle Shelby</u>			4. DATE OF DEATH Month Day Year <u>March 5, 19 67</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March 14, 1900</u>	9. AGE (In years last birthday) yrs. <u>66</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>11 21</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co., Md.</u>	
13. FATHER'S NAME <u>George Haller</u>			14. MOTHER'S MAIDEN NAME <u>Lola Younkings</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>216-48-6566</u>		17. INFORMANT Address <u>Mrs. Virginia Hutzell, Rfd. 2, Boonsboro, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4221</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 1, 1967</u> to <u>March 5, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 4, 1967</u> , and that death occurred at <u>11:00</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>G. W. LeVan</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 7, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>		22d. ADDRESS <u>Boonsboro Washington</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-8-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Middletown, Md.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</u>			25a. REC'D BY REGISTRAR <u>MAR 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

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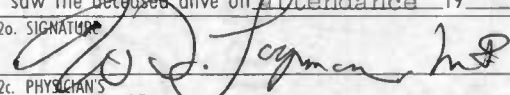

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04340

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 4 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Coffman Home for Aging				d. STREET ADDRESS Springfield State Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELSIE Middle MAY Last SHIPP				4. DATE OF DEATH March 18 1967 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6 1895	
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		11. BIRTHPLACE (County & State, or foreign country) Pa. Mercersburg Franklin Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cyrus J. Shipp				14. MOTHER'S MAIDEN NAME Mary Blair			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 15-14-1904		17. INFORMANT Address Mrs Marie Heyworth 66 West Side Ave Hagerstown Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic heart disease DUE TO (c) Unknown							INTERVAL BETWEEN ONSET AND DEATH 30 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Mar. 18 , 19 67 to Mar. 18 , 19 67 , that (I) (we) last saw the deceased alive on Mar. 18 , 19 67 , and that death occurred at 11:55 M , from causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED Mar 21, 1967		22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.	
22d. ADDRESS 100 Professional Arts Bldg, Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/22/67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Hagerstown Md Andrew K. Coffman Funeral Home Inc				25a. REC'D BY REGISTRAR MAR 22 1967		25b. REGISTRAR'S SIGNATURE 	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04341
CERTIFICATE OF DEATH
04342

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RFD 1, Clear Spring</u> d. STREET ADDRESS <u>RFD 1, Clear Spring</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Allen Shirley</u>		4. DATE OF DEATH Month Day Year <u>March 5th, 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 13, 1907</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) Months Days Hours Min. <u>21</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Wash. Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edwin T. Shirley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Hull</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Edwin T. Shirley</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7545 Congenital Heart disease</u> DUE TO (b) <u>Branchopneumonia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Meningo-myelocytic Clubhands & feet</u>		INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u> <u>20 days</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/13/1967</u> , to <u>3/5/1967</u> , that (I) (we) last saw the deceased alive on <u>3/4/1967</u> , and that death occurred at <u>5:25 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>J. M. Bacon</u>		22b. DATE SIGNED <u>3/6/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 7, 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Park Head</u>		23d. LOCATION (City, town or county) (State) <u>Wash. Co. Maryland</u>	
24. FUNERAL DIRECTOR <u>Donald E. Thompson</u>		25a. REC'D BY REGISTRAR <u>MAR 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04342		04343	
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILLIAMSPORT		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
c. LENGTH OF STAY IN 1b 3 YRS.		d. STREET ADDRESS 309 S. MULBERRY ST.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOMEWOOD CHURCH HOME, INC.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ANNA MAY SIGLER		4. DATE OF DEATH Month Day Year MARCH 21 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/28/1870
9. AGE (In years last birthday) 96		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISAAC REYNOLDS		14. MOTHER'S MAIDEN NAME ANN REBECCA FULTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-52-2109J1	
17. INFORMANT MR. VERNON R. SNIDER		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio Vascular Disease DUE TO (b) Senility DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH Several years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-2- , 19 64 , to 3-21- , 19 67 that (I) (we) last saw the deceased alive on 2-27- , 19 67 , and that death occurred at 7:30 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. E. W. Ditto, Jr.</i> M.D.		22b. DATE SIGNED 3-22-67	
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.		22d. ADDRESS 215 W. Washington St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE THEREOF 3/23/67	23c. NAME OF CEMETERY OR CREMATORY CAVETOWN REFORMED CHURCH	23d. LOCATION (City or Town) (County) (State) CAVETOWN WASH. MD.
24. FUNERAL DIRECTOR <i>W. J. Norman, Hagerstown, Md.</i>		25a. REC'D BY REGISTRAR MAR 27 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04343

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04344

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 15 Young Ave.				d. STREET ADDRESS 15 Young Ave.			
3. NAME OF DECEASED (Type or print) Guy Wilbur Smith				4. DATE OF DEATH Month March Day 17 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 22, 1900		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months 2 Days 25 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Aircraft		11. BIRTHPLACE (State or foreign country) Boonsboro, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Donivan C. Smith				14. MOTHER'S MAIDEN NAME Martha E. Lapole			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220-05-6807		17. INFORMANT Mrs. Myrtle E. Smith, 15 Young Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Thrombosis Few minutes DUE TO (b) Arteriosclerotic Vascular Disease DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr. M.D.				22. DATE SIGNED 3-18-67			
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				Address (Street, city, town, or county) Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-20-67		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION (City or Town) (County) (State) Boonsboro, Md.	
24. FUNERAL DIRECTOR John H. East, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR MAR 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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04344

CERTIFICATE OF DEATH

04345

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chewsville P.O. Box 92</u>			c. LENGTH OF STAY IN TB <u>11 Yrs</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chewsville Box # 92</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Waltz Road</u>				d. STREET ADDRESS <u>Waltz Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VICTOR</u> Middle <u>(NMN)</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 10 1894</u>	9. AGE (In years last birthday) <u>72</u> yrs.	10. UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>	11. UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Bank</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Penn. Carnegie Alleganey Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Joseph A. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Keuster</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>567-01-2796</u>		17. INFORMANT <u>Mrs Corena Smith Chewsville Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastases, abdominal & generalized</u> 1527 DUE TO (b) <u>Sarcoma, primary in jejunum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO				INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>3 months</u> <u>certain</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>Feb. 28</u> , 1967, to <u>Mar. 8</u> , 1967, that (I) <u>(we)</u> last saw the deceased alive on <u>Mar. 8</u> , 1967, and that death occurred at <u>6:15 M</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>William T. Layman, M.D.</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>	
22d. ADDRESS <u>100 Professional Arts Bldg, Hag., Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Mem. Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash Co Md</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman Funeral Home Inc</u>				25a. REC'D BY REGISTRAR <u>MAR 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04345

04346

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pa. b. COUNTY Franklin			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN lb Waynesboro			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Washington County Hospital				d. STREET ADDRESS 22 Mt. Airy Ave.			
3. NAME OF DECEASED (Type or print) First Hypatia Middle Ann Last Snider				4. DATE OF DEATH Month March Day 6 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4/6/1896		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Waynesboro Pa.		11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles D. Snider				14. MOTHER'S MAIDEN NAME Mamie Stewart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Paul McFerren, Waynesboro Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Ventricular Fibrillation DUE TO Acute Ischemic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from March 1967 , to March 1967 , that (I) (we) last saw the deceased alive on March 4, 1967 , and that death occurred at 2:40 PM , from causes and on the date stated above.							
22a. SIGNATURE Edson B. Moody		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/6/67			
22c. PHYSICIAN'S NAME (Type) Edson B. Moody		22d. ADDRESS 145 S. PROSPECT ST. HAGERSTOWN, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/9/67		23c. NAME OF CEMETERY OR CREMATORY Price		23d. LOCATION (City or Town) (County) (State) Waynesboro #2, Franklin Pa.	
24. FUNERAL DIRECTOR Walter Y. Grove				ADDRESS Waynesboro Pa.		25a. REC'D BY REGISTRAR MAR 8 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

04382

04382

RECORD OF DEATH

Washington

Washington

U. S. A. Washington County, Colorado

25 Nov. 1914

Female

Female

Age

1 year 25

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Charles H. Grier

Charles H. Grier

To

Mrs. Paul Grier, Washington

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Trion

1914

Washington Co.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04346						04347					
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>146 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route #1 Sharpsburg</u>				d. STREET ADDRESS <u>211</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport Sanitarium</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First <u>George</u> Middle <u>Robert</u> Last <u>Snyder</u>			4. DATE OF DEATH			Month <u>MARCH</u> Day <u>24</u> Year <u>1967</u>		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 24, 1879</u>		9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>City Park</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Scrapple West Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>John Snyder</u>						14. MOTHER'S MAIDEN NAME <u>Katherine Elizabeth Mimmich</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215 20 8456 A</u>		17. INFORMANT Address <u>Mrs. Mary Hensell Rt #1 Sharpsburg, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Atherosclerosis</u> DUE TO (c) <u></u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u></u> , 19 <u></u> , that (I) (we) last saw the deceased alive on <u>March 22</u> 19 <u>67</u> , and that death occurred at <u>7 P.</u> M. from the causes and on the date stated above.											
22a. SIGNATURE <u>M. E. Byrkit</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-27-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>M. E. BYRKIT</u>						22d. ADDRESS <u>28 West Potomac Street Williamsport, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>March 28-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Reform Church Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Shepherdstown, W. Va.</u>			
24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport, Md.</u>						25a. REC'D BY REGISTRAR <u>MAR 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

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UNITED STATES OF AMERICA

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UNITED STATES OF AMERICA
DEPARTMENT OF THE TREASURY
BUREAU OF THE MINT
WASHINGTON, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04347

CERTIFICATE OF DEATH

04348

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>50 Years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>101509 Virginia Ave.</u>		d. STREET ADDRESS <u>1509 Virginia Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Alvey</u> Last <u>Snyder</u>		4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 10, 1883</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sexton</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Church</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Mt. Carmel, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jacob Milton Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Ella Hildebrand</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>220-16-0812</u>	
17. INFORMANT <u>Hagerstown, Md.</u>		Mrs. Goldie D. Snyder, 1509 Virginia Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> DUE TO 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Vascular Disease</u> DUE TO (c) <u>Leukemia Lymphatic Chronic</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Several days</u> <u>5 years</u> <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1963</u> , to <u>March 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 13, 1967</u> , and that death occurred at <u>5 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>March 17, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		22d. ADDRESS <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-18-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Salem Reformed Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rural Hagerstown, Md.</u>
24. FUNERAL DIRECTOR <u>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</u>		25. REC'D BY REGISTRAR <u>MAR 21 1967</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

06321

06318

EXHIBIT OF

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "EXHIBIT" and "UNITED STATES" are visible.]

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04348

CERTIFICATE OF DEATH

04349

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>21-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON COUNTY HOSPITAL</u>		d. STREET ADDRESS <u>43 MEALEY PARKWAY</u>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>GIRL</u> Last <u>STEWART</u>		4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-31-67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON Co. MARYLAND</u>
13. FATHER'S NAME <u>LAURENCE EVERETT STEWART</u>		14. MOTHER'S MAIDEN NAME <u>ALICE MACARTHUR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>MOTHER</u> Address <u>43 MEALEY PKWY.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7625 Citelactaxis</u> DUE TO (b) <u>Immaturity</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/31</u> , 19 <u>67</u> , to <u>3/31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/31</u> 19 <u>67</u> , and that death occurred at <u>4:00</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>F. D. Dove Jr.</u>		22b. DATE SIGNED <u>4/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>F. D. DOVE, JR., M.D.</u>		22d. ADDRESS <u>214 N. POTOMAC ST., HAGERSTOWN, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>APRIL 5, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON COUNTY HOSPITAL</u>	23d. LOCATION (City or Town) (County) (State) <u>HAGERSTOWN WASH. MD.</u>
24. FUNERAL DIRECTOR <u>John Schaffer, adm. Wash. Co. Hosp</u>		25. RECEIVED BY REGISTRAR DATE <u>APR 6 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04349

CERTIFICATE OF DEATH

04350

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 144 So Mulberry St	
3. NAME OF DECEASED (Type or print) CLARENCE WILLIAM STOUFFER		4. DATE OF DEATH March 8 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Dec. 16 1883
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt of Mails U.S. Post Office		11b. KIND OF BUSINESS OR INDUSTRY Retired	
12. BIRTHPLACE (County & State, or foreign country) Downsville Wash Co		13. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME W. Cornelius Stouffer		14. MOTHER'S MAIDEN NAME Emma C. Hull	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-28-6873	
17. INFORMANT John R. Stouffer Sr		Address Hagerstown	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma larynx</u> DUE TO (b) <u>161X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/2</u> , 1963, to <u>3/8</u> , 1967, that (I) (we) last saw the deceased alive on <u>3/3/67</u> 19, and that death occurred at <u>6:40 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert V. Campbell</u>		22b. DATE SIGNED <u>3/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert V. Campbell</u>		22d. ADDRESS <u>Hagerstown Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/12.67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Bakersville Wash Co Md</u>
24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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STATE OF TEXAS

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COUNTY OF DALLAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04350

CERTIFICATE OF DEATH

04351

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN TB 47 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MARTIN MANOR CONV. HOME		d. STREET ADDRESS 1004 MULBERRY AVENUE	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle GASKILL Last TOMLINSON		4. DATE OF DEATH Month MARCH Day 9 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 2, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	9. AGE (In years lost birthday) yrs. 69
11. BIRTHPLACE (County & State, or foreign country) PHILADELPHIA CO., PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT S. TOMLINSON		14. MOTHER'S MAIDEN NAME MARY NEALL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-10-4622	
17. INFORMANT MRS. LOUISE TOMLINSON		Address HAGERSTOWN, MARYLAND 1004 MULBERRY AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Proteus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive and atherosclerotic heart disease. Malignant tumor of prostate--paraganglioma			INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from December 1965 to March 9, 1967 , that (I) (we) last saw the deceased alive on March 9, 1967 , and that death occurred at 7:50 PM , from causes and on the date stated above.			
22a. SIGNATURE W. T. Layman		22b. DATE SIGNED March 10, 1967	
22c. PHYSICIAN'S NAME (Type) WILLIAM T. LAYMAN M.D.		22d. ADDRESS PROFESSIONAL ARTS Bg. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MARCH 13, 1967	23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, MARYLAND
24. FUNERAL DIRECTOR CHARLES M. ROUZER		ADDRESS HAGERSTOWN, MARYLAND	
25a. REC'D BY REGISTRAR DATE MAR 15 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

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[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
20 M 1/66

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04351

CERTIFICATE OF DEATH

04352

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonesboro</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Reeder Nursing Home</u>		d. STREET ADDRESS <u>231 Westside Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Alverta</u> Last <u>Troup</u>		4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1880</u>
9. AGE (In years last birthday) yrs. <u>86</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hanover, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Ernst</u>		14. MOTHER'S MAIDEN NAME <u>Lidia Auchey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>175-10-5886</u>	
17. INFORMANT <u>Mr. Clair H. Troup 231 Westside Ave.</u>		Address: <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardio vascular</u> DUE TO (b) <u>disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 7, 1967</u> , to <u>March 14, 1967</u> , that (I) (we) lost the deceased on <u>March 11, 1967</u> , and that death occurred at <u>11A</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>G. Wike Van</u>		22b. DATE SIGNED <u>3-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Wike Van</u>		22d. ADDRESS <u>Boonesboro, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/16/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Washington, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Ernst</u>		25a. REC'D BY REGISTRAR <u>MAR 16 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
04352					04353						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <u>Washington</u>			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keedysville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keedysville</u>			d. STREET ADDRESS <u>54 N. Main St.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>54 N. Main St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <u>Thomas Ray Valentine</u>					4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1967</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 16, 1905</u>		9. AGE (In years last birthday) <u>61</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Upholster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Keedysville, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				
13. FATHER'S NAME <u>William A. Valentine</u>					14. MOTHER'S MAIDEN NAME <u>Martha Emerson</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>			16. SOCIAL SECURITY NO. <u>214-09-6677</u>		17. INFORMANT <u>Mr. C. Foster Valentine, Keedysville, Md.</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarct</u> DUE TO (b) <u>Atherosclerotic heart disease</u> DUE TO (c) <u>1 year</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12-1-1965</u> to <u>3-3-1967</u> , that (I) (we) last saw the deceased alive on <u>3-3-1967</u> , and that death occurred at <u>8 P.M.</u> from causes and on the date stated above.											
22a. SIGNATURE <u>Joseph Secordari</u>					22b. DATE SIGNED <u>3-4-67</u>		22c. PHYSICIAN'S NAME (Type) <u>JOSEPH SECORDARI</u>				
22d. ADDRESS <u>Boonsboro Md</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-6-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Keedysville, Md.</u>				
24. FUNERAL DIRECTOR <u>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</u>					25a. REC'D BY REGISTRAR <u>MAR 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

00333

STANDARD OF DEATH

00333

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04353

CERTIFICATE OF DEATH

04354

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 324 Vista St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DORIS MARIE VULGAMOTT		4. DATE OF DEATH Month March Day 26 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1921
9. AGE (In years last birthday) yrs. 46		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Dorrick F. Byrd		14. MOTHER'S MAIDEN NAME Agnes B. Ashby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Jack Osborne, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 490X IMMEDIATE CAUSE (a) Right Lobar Pneumonia DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recent Fall		INTERVAL BETWEEN ONSET AND DEATH 7 days	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-23 , 19 67 , to 3-27 , 19 67 , that (I) (we) last saw the deceased alive on 3-27 , 19 67 , and that death occurred at 10:41 AM , from causes and on the date stated above.			
22a. SIGNATURE E. J. LaRocca		22b. DATE SIGNED 3-27-67	
22c. PHYSICIAN'S NAME (Type) E. J. LaRocca		22d. ADDRESS 300 W. North Main, Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3-29-67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE MAR 30 1967	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04354

CERTIFICATE OF DEATH

04355

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pen Mar, Penna.		c. LENGTH OF STAY IN 1b 47 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pen Mar, Penna.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Earl Middle Dean Last Werdebaugh			4. DATE OF DEATH Month March Day 27 Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/23/1892		9. AGE (In years last birthday) yrs. 74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railway Express		11. BIRTHPLACE (County & State, or foreign country) Franklin, Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Harry S. Werdebaugh		
14. MOTHER'S MAIDEN NAME Laura Greenwood			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		
16. SOCIAL SECURITY NO. 715-03-4676			17. INFORMANT Mrs. Thelma Werdebaugh Address Box 44 Pen Mar, Penna.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arteriosclerotic Cardiac Vascular Disease DUE TO (c) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 45 minutes 5-7 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from March 27, 1967 , to March 27, 1967 , that (I) (we) lost the deceased alive on March 27, 1967 , and that death occurred at 11:45 M. from causes and on the date stated above.					
22a. SIGNATURE Robert A. Kiefer, M.D.		22b. DATE SIGNED 28 March 1967		22c. PHYSICIAN'S NAME (Type) Robert A. Kiefer, M.D.	
22d. ADDRESS Blue Ridge Summit, Pa.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 3/30/1967		23c. NAME OF CEMETERY OR CREMATORY Burns Hill		23d. LOCATION (City or Town) (County) (State) Waynesboro, Franklin, Pa.	
24. FUNERAL DIRECTOR Walter G. Grace		ADDRESS Waynesboro, Penna.		25a. REC'D BY REGISTRAR MAR 30 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04355

CERTIFICATE OF DEATH

04356

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garlock Mem. Convalescent Hospital		d. STREET ADDRESS 115 N. Main St.	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Louise Wheeler		4. DATE OF DEATH Month Day Year March 2, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1882
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 1 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Boonsboro, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Wheeler		14. MOTHER'S MAIDEN NAME Laurette Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Charles L. Meredith, Boonsboro, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of maxillary bone DUE TO (b) and includes CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 10 Mon	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 1, 1967 to March 2, 1967 , that (I) (we) last saw the deceased alive on March 1, 1967 , and that death occurred at 11 A M, from causes and on the date stated above.			
22a. SIGNATURE G. W. Hevan		22b. DATE SIGNED March 3, 1967	
22c. PHYSICIAN'S NAME (Type) G. W. Hevan		22d. ADDRESS Boonsboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-4-67	23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery	23d. LOCATION (City or Town) (County) (State) Boonsboro, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25. REC'D BY REGISTRAR MAR 7 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04356

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04357

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 Week</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. STREET ADDRESS <u>2417 Penna Ave</u>	
3. NAME OF DECEASED (Type or print) <u>GOLDIE DOROTHY DAY-WHITE</u>		4. DATE OF DEATH <u>March 22 1967</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14 1888</u> 78 yrs.
9. AGE (In years last birthday) <u>78</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Tyson Dameron</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Barnes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>523-30-0086A</u>	
17. INFORMANT <u>Eldon J. Day</u>		Address <u>2417 Penna Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intercerebral hemorrhage</u> DUE TO (b) <u>athrosclerosis, cerebral</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus; incidental fracture, left hip</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. fell at home while getting into bed on 3/14/67</u>	
20c. TIME OF INJURY Month, Day, Year <u>10:00 p.m. 3/14 19 67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Howard N. Weeks, M.D.</u>		3/22/67 22. DATE SIGNED	
EXAMINER'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>580 Northern Ave.</u> Address (Street, city, town, or county) <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>3/23/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Carmel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Huntsville Randolph Co Mo</u>
24. FUNERAL DIRECTOR <u>Andrew K. Coffman Funeral Home Inc</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04357

04358

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 14 Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Dollie May Wolfe		4. DATE OF DEATH Month Day Year March 30, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1876
9. AGE (In years lost birthday) 90 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Zittlestown, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Simon Summers		14. MOTHER'S MAIDEN NAME Buma Zittle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 213-48-6193	
17. INFORMANT Mrs. William Lowery, Rfd. 4, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric thrombosis 450.0 DUE TO (b) arteriosclerotic disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January, 1966 , to March, 1967 , that (I) (we) last saw the deceased alive on March 30, 1967 , and that death occurred at A M, from causes and on the date stated above.			
22a. SIGNATURE Howard N. Weeks, M.D.		22b. DATE SIGNED 3/31/67	
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		22d. ADDRESS 580 Northern Ave. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-1-67	23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery	23d. LOCATION (City or Town) (County) (State) Boonsboro, Md.
24. FUNERAL DIRECTOR John H. Best, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR APR 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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